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ABSTRACT

The materials contained in this Early Integration Training Project manual are designed for trainers who are interested in facilitating an increase in the integrated options available for young children with disabilities and their families. The training is more process than content oriented and is highly dependent upon group interactions. It provides opportunities for participants to build local linkages and to impact local issues. Key themes in the project suggest that: environments for all learners need to be emotionally secure and physically safe; learning can be enhanced through individualization; and all learners have a variety of strengths and needs. The training materials are divided into four content areas or modules: (1) "What Is Integration?" which provides information on integration and quality programming for young children with disabilities; (2) "Who Are the Children?" which provides information on the abilities and needs of young children with and without disabilities; (3) "Who Are the Adults?" which provides information on options for integrated programs and identifies the roles, responsibilities, and areas of expertise of the adult team members; and (4) "Problem Solving Strategies and Preparation for Integration" which provides solutions to identified barriers to integration. Each module comprises four sections: module text, training activities, forms for overhead transparencies, and summary papers. (JDD)

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THE EARLY INTEGRATION TRAINING PROJECT

TRAINER'S MANUAL

THE
EARLY
INTEGRATION
TRAINING PROJECT

EDITED BY

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The training modules were piloted in four counties in Ohio during 1990: Athens, Franklin, Richland, and Muskingum. Project staff were assisted in each pilot county by local staff interested in providing integrated options for young children with disabilities. Their help was invaluable during the piloting of the project. They are: Dee Dee Dransfield and Jean Coey (Athens county); Ellen Gow and Rhonda Dickson (Franklin county); Carol Liles (Richland county); and, Linda Huston and Elizabeth Libben (Muskingum county);

Via the expertise of the project's Regional Coordinators, the training modules were introduced to other counties in Ohio after the piloting phase. Their experience with young children and expertise in facilitating training was invaluable. The Regional Coordinators are: Lisa Barnhouse, Cindy Detweiler, Dee Dee Dransfield, Leah Holden, Maria Kaiser, Fran Landers, Penny Meuller, and Carol Quick.

A number of individuals contributed to the Early Integration Training Project during its evolution. The project materials were developed and refined over a period of several years through a process that involved the expertise of professionals from a variety of disciplines. The people whose contributions have been essential to the development of the training modules are listed on page iii.

Thanks are also extended to the Early Integration Training Project's advisory committee and all the training participants who provided valuable feedback concerning the project's activities.

Information about the training approach is available from:

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Additional copies of the trainers manual and other training materials are available by contacting:

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I. INTRODUCTION TO THE MODULES

The materials contained in this volume are designed for trainers who are interested in facilitating an increase in the integrated options available for young children with disabilities and their families. The training is designed to be more process than content oriented. It provides opportunities for participants to build local linkages and to impact local issues surrounding the integration of young children with disabilities. The audience for the training is intended to be drawn from a wide range of disciplines and interests, such as: family members of children with and without disabilities, special education staff, early childhood staff, related services personnel and administrators from both regular and "special" early childhood programs. The training is highly dependent upon group interactions; for best results, a mixed audience is highly recommended.

The training materials are divided into four content areas or modules:

- ☆ **What is Integration?**
- ☆ **Who are the Children?**
- ☆ **Who are the Adults?**
- ☆ **Problem Solving Strategies and Preparation for Integration.**

The complete modules should take approximately 15 hours to complete. The trainer is encouraged to review the training activities and overheads to determine the handouts that will be needed for each participant. The trainer may wish to copy the summary papers, key idea overheads, and activity handouts for each participant.

II. MODULE FORMAT

Each of the four modules in The Early Integration Training Project's Trainer's Manual follows a consistent format and is comprised of four sections. The sections, Module Text, Training Activities, Overhead Transparencies, and Summary Papers, are described below:

A. Module Text

The module text section consists of the module overview, summary training outline, and content narrative. The module overview includes information on the purpose and goals of the module, participants' and trainer's expectations, the length of the training, and additional resources suggested to the trainer. The summary training outline is a brief outline of the training content for that particular module. It is designed to be used by the trainer as a framework for delivering the content of the training. The content narrative is a detailed outline of the information to be provided to participants for the given module. Throughout the content narrative, references for the appropriate times to display specific overhead transparencies and facilitate training activities are given. The module text section also includes an evaluation of the training module. Participants should complete each module evaluation as the modules are completed by the trainer.

B. Training Activities

Training activities have been suggested and described in detail in this section. Information is provided on the purpose of the training activity, the length of time required to complete the activity, and the materials needed during the activity. A description of the activity is also provided. Often, there is more than one training activity suggested to reinforce a particular idea. The trainer is encouraged to choose the activity that best fits the needs of the group. The trainer is also encouraged to substitute another activity if it meets the purpose of the original activity suggested.

C. Overhead Transparencies

Forms to make overhead transparencies are provided for each of the training modules. The overheads were designed to accompany the training, and to provide the trainer and the participants with an overview of a module's key points as they are being discussed. The trainer is encouraged to make overhead transparencies from the forms and to use them throughout the training as indicated.

D. Summary Papers

Brief summary papers are included in both the trainer's materials and the participant notes. The summary papers highlight and expand the key ideas or points in a module. Because the training modules were not designed to provide specific information on how to integrate young children with disabilities, the summary papers are a reference for participants who want additional information regarding integration.

III. HOW TO PRESENT THE MODULE

A. Trainer Competencies

The modules serve as a guide for discussing issues concerning the integration of young children with disabilities into integrated settings. They are intended for use by trainers who have competencies in the content areas described in the modules. It is recommended that trainers meet the following criteria:

☆ Experience in the content area of the module being presented.

☆ Experience in working with young children and families in integrated or regular early childhood settings.

☆ Philosophical orientation toward providing integrated options for young children with disabilities in the context of a family centered approach.

☆ Demonstrated abilities to communicate clearly and effectively.

☆ Demonstrated abilities in providing effective inservice training (e.g., multisensory approaches, facilitating group discussions, facilitating training activities, etc.).

B. Trainer Preparation

Prior to the training session, it is recommended that the trainer read the summary papers and recommended resources for each module . The trainer should be familiar with the outline and content of the module and should be able to relay the information using functional examples related to working with a variety of infants and children between the ages of birth through eight years. The trainer should also review all of the training activities and audiovisual materials, and prepare any necessary materials prior to the training session.

C. Special Instructions

The trainer should be sensitive when addressing the handicapping conditions of an individual by acknowledging the individual first and the disability second. For example, trainers should use the reference "infant with a hearing impairment" rather than "deaf infant".

D. Training Tips

☆ It is recommended that the audience size be kept to 10 - 30 participants in order to encourage an open exchange of information. The training works best when the audience represents many different backgrounds and roles.

☆ Participants should be encouraged to ask questions, provide personal examples, and discuss the ideas presented. Participant input is a key part of each training module.

☆ Throughout the text are sections called ***Key Ideas***. These sections give a brief summary of the upcoming module content. It is hoped that the ***Key Ideas*** will give trainers a clear idea of the emphasis of the content.

☆ Each module is written in outline form to provide a basic framework for presenting the information. Throughout the outline, icons are provided as a cue for the transparency to be used, or the activity to be performed.

☆ Training activities have been suggested and described. The training activities should provide participants an opportunity to further discuss and explore the information provided.

☆ The module is designed to be supplemented by overhead transparencies and other audiovisual materials. The trainer is encouraged to include additional audiovisual materials as time permits.

☆ Suggested placement for the training activities and overhead transparencies are given in the left margin of the text. The following two icons are used to indicate activities and overheads.

🏃🏃 **= Activities** ▭ **= Overheads**

E. Key Themes

Trainers should review the key themes of the Early Integration Training Project with participants. Some of the themes will be highlighted in each of the different modules. It should be noted that the key themes apply to participants as they work with children, and as they participate in the training sessions.

☆ **Environments for all learners need to be emotionally secure and physically safe.**

- Secure relationships enhance learning
- Autonomy and decision making abilities support learning
- Accurate, understandable information enhances the learning environment
- Within a secure learning environment we are both teachers and learners

☆ **Learning can be enhanced through individualization**

- Individualization can and does occur within group settings
- Social interactions with a variety of peers and adults can enhance learning

☆ **All learners have a variety of strengths and needs**

- You don't need to segregate to teach
- You don't need to segregate to learn

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

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1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

I. MODULE OVERVIEW

LENGTH OF TRAINING

This module is designed to be completed in one, 3 1/2 hour session. This time allotment includes approximately 30 minutes for breaks and for completing participant registration. Breaks may be inserted as needed during the training. Recommended time frames for each of the content sections have been provided in the Summary Training Outline and throughout the text. It is recommended that the second session, Module 2, be conducted 2-7 days following the completion of Module 1. This time frame will allow participants an opportunity to complete the Field Exercises while keeping the information current.

A. Purpose and Goals

Purpose: To provide information on integration and quality programming for young children with disabilities.

Goal 1: To provide an overview of the positive outcomes which can be expected through well-planned, integrated programs.

Goal 2: To provide information related to a family centered approach to providing quality programming for young children with disabilities.

Goal 3: To provide participants an opportunity to identify barriers to providing well-planned, integrated programs in their community.

B. Participant and Trainer Expectations

The trainer should present the following expectations to participants. The expectations should be used as a guide by the trainer to insure that all material is covered during the training session.

1. The trainer will provide participants with the information to be able to understand the philosophical and legislative history of integration for young children with disabilities.

2. The trainer will provide participants with the information to be able to discuss the positive aspects of integrated programs for young children with disabilities.

3. The trainer will provide participants with the opportunity to explore their feelings and values related to the integration of young children with disabilities.

4. The trainer will provide participants with information concerning a family centered approach to providing quality programming for young children with disabilities.

5. The trainer will provide participants with the information to be able to discuss the characteristics of a well-planned, integrated program.

6. The trainer will provide participants with the information to be able to describe local barriers to providing integrated programs for young children with disabilities.

C. Additional Resources for the Trainer

Biklen, D., Lehr, S., Searl, S., & Taylor, S.(1987) *Purposeful Integration... Inherently Equal.* Syracuse, New York: The Center on Human Policy, Syracuse University.

Dunst, C., Trivette, C., & Deal, A. (1988). *Enabling and empowering families: Principles and guidelines for practice.* Cambridge, MA: Brookline Books.

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Early Integration Training Project (Producer). (1991). *Together We're Better.* (Videotape). Columbus, OH: The Ohio State University, Center for Special Needs Populations.

Family Network (Producer). (1991). *On this journey together: Parent/ Professional partnership.* New Lexington, OH: The Family Network.

Kaiser, C. (1982). *Not in my class: Understanding mainstreaming* (Videotape). Columbus, OH: Electro Systems, Inc.

Gallagher, J., Trohanis, P., & Clifford, R. (1989). *Policy implementation and PL 99-457: Planning for young children with special needs.* Baltimore, MD: Paul H. Brookes Publishing, Co.

Ohio Department of Education, Division of Early Childhood Education. (Draft, 1991). Early Childhood Special Education and Ohio Public Schools: Chronology of Major State-Level Legislative and Policy Initiatives. *Rules implementation monograph series for rules for the education of preschool children with disabilities served by public schools and county boards of mental retardation and developmental disabilities,* (Monograph No. 1). Columbus, OH: Author.

Ohio Department of Education, Division of Early Childhood Education. (Draft, 1991). Program Planning in Early Childhood Special Education. *Rules implementation monograph series for rules for the education of preschool children with disabilities served by public schools and county boards of mental retardation and developmental disabilities,* (Monograph No. 2). Columbus, OH: Author.

Powell, D. (1989). Families and early childhood programs. *Research Monographs of the National Association for the Education of Young Children,* 3 (Serial No. 142).

NOTES

II. SUMMARY TRAINING OUTLINE

The summary training outline is provided to trainers as an organizational tool. It describes the basic outline of the content, appropriate places for training activities, and the presentation of audiovisual materials. A space has also been provided for making notes about materials, equipment and other training needs.

Key:

🏃 - Activity ▭ - Overhead

LENGTH OF TRAINING FOR EACH SECTION

30 *minutes*

Opening Discussion

- Introductions 🏃 #1
- Review of Module Goals ▭ #1-6
- Expectations & Themes

NOTES

40 *minutes*

What is Integration? ▭ #7

🏃 #2 or 3

- Definition of Integration ▭ #8

- **Definition of Other Terms Related to Integration** #9

#4 or #5

NOTES

30
minutes

Philosophical & Legal Trends

of Integration #10-13

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- Civil Rights Act
- Concept of Normalization
- Significant State Decisions
- Section 504 of the Rehabilitation Act
- P.L. 94-142
- P.L. 99-457
- P.L. 101-336, Americans with Disabilities Act
- Ohio State Legislation

NOTES

30 *minutes*

Research in Support of Integrated Settings

#14-15

- Benefits for Young Children
- Benefits for Families
- Benefits for Nonhandicapped Peers

NOTES

30 *minutes*

The Importance of the Family Centered Approach

#16-17

- System Centered Approach
- Child Centered Approach
- Family Centered Approach

#6, #7, or #8

NOTES

20
minutes

Characteristics of a Well-Planned Integrated Program

#19-20

- Program Philosophy
- Concept of Integration
- Collaborative Planning
- Adaptation of Regular Activities
- Parent Involvement

#9

NOTES

#4 - 6 & 21

30
minutes

Closing Discussion

#10

- Journal
- Review Expectations & Themes
- Review Field Exercises & Future Sessions
- Collect completed Workshop Evaluations

NOTES

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

III. WHAT IS INTEGRATION?

#7

***KEY IDEA*:** The idea of placing children with disabilities in regular education settings has a long history in the United States. However, the words used to talk about the idea have changed and have evolved with the philosophy. The purpose of this section is to describe the terms related to integration and to show how they reflect the movement from mainstreaming to integration to inclusion.

#2 or #3

#8

A. Definition of Integration

The following definition of integration, although focused on the school aged population, is relevant for infants and preschool children with disabilities.

> *Integration is a broad term which refers to the opportunities for the student with a disability to have access to, inclusion in, and participation in all activities of the total school environment. Effective integration means planning and providing maximal opportunities for interaction between non-disabled students and their peers who have disabilities. These interactions can and should occur in a variety of settings and ways.*
> *(Biklen, Lehr, Searl, & Taylor, 1987, p 11.).*

#9

B. Definition of Other Terms Related to Integration

1. Normalization

This term was popularized in Scandinavia and refers more specifically to the approach which should be used by the various providers who serve individuals with disabilities. It stresses that individuals with disabilities should experience patterns of life and conditions of every day living which are as close as possible to the regular ways of life in their society.

2. Least Restrictive Environment (LRE)

A legal term used primarily in reference to situations in which individuals are being confined against their will as in commitment proceedings to a mental health institution. The term was utilized in the regulations for the Education of the Handicapped Act (P.L. 94-142) to describe the educational placement which, for a particular child with disabilities, is closest to the regular classroom while being appropriate to the child's educational needs.

3. Mainstreaming

A term popular in the educational community. It means putting a child with disabilities into the regular classroom. The underlying premise in the term is that the child will be able to succeed using the regular curriculum with appropriate supports.

4. Inclusion

The meaning of this term is rather broad and refers to the easy access and involvement of individuals or groups in the various activities of a particular community. The term refers to all members of a community and assumes that membership in the community should be given.

NOTE: To further clarify the term "inclusion," the trainer may wish to direct participants' attention to differences between the terms "integrated," "mainstreamed" and "included." While participants may not be able to recall when they were "integrated" or "mainstreamed," they should be able to recall times when they felt "included" or "excluded."

#4 or #5

NOTES

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

IV. PHILOSOPHICAL AND LEGAL TRENDS OF INTEGRATION

#10

KEY IDEA: The integration of individuals with disabilities has a long history in the philosophical, legal and ethical trends that have occurred during the past fifty years. Many people with disabilities have benefitted not only from the legislation focused on disabilities, but also from the legislation aimed at civil rights issues.

#11

A. Brown v. Board of Education of Topeka Kansas (1954)

This U.S. Supreme Court decision was significant in that it stated for the first time that education was a basic right subject to equal protection under the 14th Amendment of the U.S. Constitution. This was revolutionary as education is not constitutionally a federal function, but rather is delegated to the states. Though the case dealt specifically with educational segregation by race, in many ways it marked the beginning of the general Civil Rights movement and established the important precedent that "separate is not equal." The language utilized in the decision is interpreted by many to be applicable, philosophically if not legally, to the issue of the segregation of individuals with disabilities. Chief Justice Earl Warren wrote in the 1954 decision that:

> *Separate educational facilities are inherently unequal. This inherent inequality stems from the stigma created by purposeful segregation which generates a feeling of inferiority that may affect their hearts and minds in a way unlikely ever to be undone.*

B. The Civil Rights Act (1964)

This federal legislation, an outcome of the Brown v. The Board of Education decision, broadly prohibited discrimination on the basis of race in a variety of public and private enterprises. It attempted to implement the ideas of "equal opportunity" and "separate is not equal" as they applied nationally to employment, housing, etc. The act lead to a variety of legal confrontations between the federal and state/local governments.

C. Significant State Decisions

PARC v. Pennsylvania (1972) was a class action suit brought by the Pennsylvania Association for Retarded Citizens (PARC) against the Commonwealth of Pennsylvania on behalf of children with mental retardation who were excluded from public education because of their disability. Jurisdiction of the federal court was established utilizing, again, the 14th Amendment.

A consent decree was developed by the state-level federal court as the Commonwealth decided not to contest the suit. Important principles such as: "free, appropriate public education," "least restrictive environment," and "parental participation in decision making" were outlined and later utilized as the framework for P.L. 94-142.

A related case is Mills v. Board of Education (1972). The case was brought on behalf of seven students with a variety of disabilities who were being denied a public education. It was significant in that it involved the Board of Education of the District of Columbia and, as such, the 14th Amendment could not be invoked. As an alternative, the federal court utilized the due process provisions of the 5th Amendment thus broadening the precedent. Other important principles established in this case were: "zero reject," right to due process, and the right to a "free, suitable public education."

#12

D. Section 504 of the Rehabilitation Act (1973)

This piece of legislation prohibited discrimination on the basis of handicapping condition in federally funded programs. It often is related to employment practices, but can apply to any service provided by a program which receives any federal funds.

E. P.L. 94-142, The Education of the Handicapped Act (1975)

Public Law 94-142 opened up the nation's public schools to children with disabilities and stated a preference for services in integrated programs described as the "Least Restrictive Environment." The Education of the Handicapped Act was passed by the U.S. Congress in 1975 and was implemented in the fall of 1978. The principles of "zero-reject," child-find, least restrictive environment, non-discriminatory testing, due process, and parent participation were taken from the PARC, Mills and related decisions. In addition, Congress added provisions for the individualized educational plan (IEP). The law uses a funding incentive to encourage state participation.

In particular, P.L. 94-142 states that...

> *to the maximum extent appropriate, handicapped children in public and private institutions or other care facilities, are educated with children who are not handicapped, and that special classes, separate schooling, or other removal of handicapped children from the regular educational environment*

> *occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily (20 USC 1412 Section 6125b).*

The above statute was interpreted in regulations as the necessity for serving children with disabilities in the least restrictive environment. This is interpreted legally as meaning that the state must do things in a manner that least intrudes upon (restricts) individual rights. While important, this concept has been vague enough to be interpreted in a variety of ways.

The 1990 reauthorization of the Education of the Handicapped Act changed the name of the legislation to the Individuals with Disabilities Education Act (IDEA).

F. P.L. 99-457,

The Education of the Handicapped Amendments of 1986

The passage of Public Law 99-457 in 1986 served to focus national attention on services to children with disabilities, birth through age five. It amended Public Law 94-142 to mandate special education services for children down to age 3. The mandate must be in place in each state by school year 1991-92. It also implemented financial incentives for serving new children, and financial sanctions (loss of all federal preschool funds under the act) for states not complying by the deadline. Additionally, it created a voluntary program for infants and toddlers (birth through age two) with developmental delays or "at risk" of becoming developmentally delayed. This program was given a five year implementation timeline dating from the point of a state's entry. The most recent reauthorization of this program (P.L. 102-119) has extended the timelines an additional 2 years.

Both initiatives express a strong preference for integrated settings. "To the extent appropriate, early intervention services must be provided in the types of settings in which infants and toddlers without handicaps would participate" (Federal Register, June 22, 1989). The 3-5 year old federal regulations require complete compliance with the LRE provisions of P.L. 94-142, and suggest alternative methods for meeting these provisions including:

☆ Providing opportunities for the participation (including part-time) of preschool handicapped children in other preschool programs operated by public agencies (such as Head Start);

☆ Placing handicapped children in private school programs for non-handicapped preschool children or private school programs that integrate handicapped and non-handicapped children; and,

☆ Locating classes for handicapped preschool children in regular elementary schools.

While the regulations P.L. 99-457 and P.L. 94-142 state a preference for integration, considerable room for interpretation remains. The philosophical arguments remain the best justification for integrated programs. Programs which prepare children for lives in a wider world and promote normal experiences require integration. The endeavor to change attitudes about individuals with disabilities in the larger community has little chance if those individuals are "out of sight, out of mind."

G. P.L. 101-336, The Americans with Disabilities Act of 1990

This federal legislation was passed by an overwhelming majority in the U.S. Congress during the summer of 1990. It provides broad protection in employment, public accommodations, public services, transportation and telecommunications to all Americans with disabilities. While previous legislation dealt only with programs receiving federal funding, this legislation extends its reach to the private, as well as the public, sector. Most provisions of the legislation became effective in 1992.

H. Ohio's State Legislation Related to Young Children with Disabilities

In 1989, Amended Substitute House Bill 248 was passed. This bill requires that free and appropriate public education for children with disabilities be provided for children with disabilities, ages 3-5. These services, regulated by the Ohio Department of Education, Division of Early Childhood, began on July 1, 1991. The current rules and regulations provide for integrated options for young children with disabilities through a variety of alternative service delivery options. These options include itinerant services in the home or community based program, mainstreaming and reverse mainstreaming. In addition, Amended Substitute House Bill 777, passed in 1990, provides school districts the authority to contract for preschool programs with Head Start, nonprofit, licensed day care, and nonsectarian nonpublic schools. The Ohio Department of Health, the lead agency for services to children with disabilities birth through age five in Ohio, continues to work for legislation providing for increased services. They currently provide services to infants and toddlers with disavilities under the auspoces of an executive order.

NOTES

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

V. RESEARCH IN SUPPORT OF INTEGRATED SETTINGS

#14

KEY IDEA: The philosophical and legal trends toward integration have provided a moral and ethical reason for placement of young children with disabilities into regular early education programs. In addition, the research data on integration has also empirically shown evidence to support providing integrated programs. This evidence has shown the lack of benefits for children in segregated settings and the positive outcomes from participation in integrated programs.

#15

A. Benefits of Integrated Programs for Young Children with Disabilities

1. Social Skills Development

Social skills are a key behavior for young children with disabilities to learn. Social skills are the developmental skill that are most likely to lead to success in the adult world. No study that has assessed social outcomes for children within integrated versus segregated settings has found segregated settings to be superior in the development of social skills. However, social skills development must be taught through frequent planned interactions within integrated settings. The presence of nonhandicapped peers does not alone insure the development of social skills. The teacher must carefully provide structured opportunities during which social interactions can occur.

2. Integration of Different Disabilities

Studies have compared the performance of children with a variety of disabilities in both integrated and segregated settings. No evidence has been found to support the idea that some children, because of their specific disability or because of their level of impairment, are not good candidates for placement in integrated settings. Therefore, all children, regardless of their disability, can be provided integrated placements if the appropriate supports are available.

3. Maintenance and Generalization of Skills

Many studies have shown that young children with disabilities have been able to learn new skills in segregated settings. However, children have increased difficulty maintaining these skills in segregated settings. Additionally, some children with disabilities often are not able to generalize skills learned in a segregated setting to an integrated setting. Integrated programs are more likely to be characterized by more state-of-the-art practices including: extensive parental involvement, highly structured scope and method of instruction, and attention to repeated outcome assessment.

B. Benefits of Integrated Programs for Families of Young Children with Disabilities

Research has shown that one of the most important things that parents want for their young children with disabilities is the opportunity to develop friendships with nonhandicapped peers. Clearly, integrated settings offer more opportunities for the development of friendships with nonhandicapped peers than do segregated programs. Intergrated settings also provide family members with support from other families with and without disabilities. Thus expanding their support network.

C. Benefits of Integrated Programs for Nonhandicapped Peers

Many people believe that integrated placements for young children with disabilities may not benefit their nonhandicapped peers. It is thought that nonhandicapped peers would not receive enough attention or would not be challenged if a young child with disabilities was integrated into their classroom. However, nonhandicapped peers have shown only positive developmental and attitudinal outcomes from their involvement in integrated experiences.

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

VI. THE IMPORTANCE OF A FAMILY CENTERED APPROACH

#16

KEY IDEA: The family is the primary environment for the young child with disabilities. Services that are most effective for the child with disabilities occur when the family, and not just the individual child, is the focus of attention. One of the major purposes of developing a variety of service options in the community is to increase the choices for families and to maximize the potential for family support. The process for the delivery of services can be categorized in three ways: the system centered approach, the child centered approach, and the family centered approach.

#17

#6

A. System Centered Approach

This approach to providing services to young children with disabilities and their families focuses primarily on the strengths and needs of the system, rather than the strengths and needs of the family. Services are delivered to the family based on system issues rather than family issues. Child care centers that are open between 9:00 a.m. - 4:00 p.m., special education services that only offer home programming, and health care services that must be received in order for a child/family to be eligible for case management services are examples of approaches that have been developed out of system requirements. They are not based on the family's needs for assistance, and do not provide opportunities for families to determine their own need for services.

B. Child Centered Approach

The child centered approach goes a step further to meet the child's needs, but the family's needs are still not driving the delivery of services. The delivery of services is driven by the strengths and needs of the child. Some examples of the child centered approach include: center based speech-language therapy services are provided to the child while the parent stays in the waiting room; parents are not permitted to visit their child's preschool classroom because it might "disturb" the child; and, medical equipment that has been prescribed for the child is given to the family with little instruction in its use, or any discussion regarding the family's need for the equipment.

#7 or #8

C. Family Centered Approach

The family centered approach focuses on the strengths and needs of the entire family. It considers the crucial role that the family plays in their child's life. Family needs are assumed to change with time and circumstances; the delivery of services adjusts accordingly. Partnerships must be developed between families and service providers. The development of partnerships is crucial to the family centered approach. "Partnership" can be defined as a process in which professionals and the community share the family's vision of the child's future and work together toward that shared vision.

NOTES

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

VII. CHARACTERISTICS OF A WELL-PLANNED, INTEGRATED PROGRAM

#18

KEY IDEA: For integrated programs to be effective, they must be well-planned, research-based and developmentally as well as exceptionality appropriate. The development of an integrated early childhood program takes time, effort, and team work from early childhood professionals, special educators, administrators, and parents of children with and without disabilities. The development of a quality program is an ongoing process that evolves over time.

#19

A. Program Philosophy

A consistent program philosophy based on knowledge of typical and atypical early childhood development is shared, articulated and implemented by all program participants.

B. Concept of Integration

The program promotes the concept of integration, which means that children with and without disabilities share common settings and good relationships.

#20

C. Collaborative Planning

The family and staff from all environments in which the child participates have many opportunities for collaborative, comprehensive planning.

D. Adapt Regular Activities

The learning needs of children with disabilities are met through adapting regular activities and materials.

#9

E. Parent Involvement

Parents are provided multiple opportunities for involvement in their child's program and have a great degree of control in choosing these options.

NOTES

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

VIII. CLOSING DISCUSSION

#10

A. Journal

Ask participants to take five minutes to make an entry into their journal. The entry should be about their own thoughts and feelings related to the information and ideas discussed in the workshop.

#21 & 22

B. Review Field Exercises

To complement the discussion on children with disabilities, the trainer may ask the participants to do one or more of the following field exercises. Review possible field exercises with participants. Offer the option to do another activity related to the topic. Make sure that participants understand the activities and their responsibility in completing them.

1. Interview two or more different people (adults and/or children) about their views concerning the integration of children and adults with disabilities into the community. How do their thoughts relate to the barriers identified in this session.

2. Arrange to visit one of the other programs represented in the group. This may be done individually or in groups. Visit a program that is new to you.

3. Interview a person with disabilities or parent of a child with disabilities. What were their experiences with early childhood education? What were their experiences with integration?

4. Identify one barrier within your current setting. Think of possible strategies to overcome the barrier. Ask others in your setting for possible solutions. Begin to implement one strategy that was suggested.

5. Read a local newspaper, magazine or watch the local news on television. Are there any stories related to integration or persons with disabilities? What did you learn about persons with disabilities through the media? Keep a journal for a week that records your observations related to the kind of information that is presented on persons with disabilities.

6. Generate your own field exercise.

#4-6

C. Review Participant and Trainer Expectations and Themes

The purpose of this discussion is to review the participant and trainer expectations and training themes to ensure that all training needs have been addressed.

D. Review of Future Sessions

Briefly review the next module's content and format with participants.

E. Workshop Evaluation

Ask participants to complete the workshop evaluation for Module One.

NOTES

IX. WORKSHOP EVALUATION

Code: ____________________ Date: ________________________

Training Site: ____

Please read each of the following statements carefully and rate each statement using the following codes:

1= Strongly Disagree (SD)
2= Disagree (D)
3= Undecided (U)
4= Agree (A)
5= Strongly Agree (SA)

	(SD)	(D)	(U)	(A)	(SA)
1. Overall, the content of this workshop met my expectations.	1	2	3	4	5
2. I gained new knowledge as a result of this workshop.	1	2	3	4	5
3. The workshop was organized and well structured.	1	2	3	4	5
4. I was provided an opportunity to discuss the ideas presented in the workshop.	1	2	3	4	5
5. I was provided with an opportunity to interact with fellow participants.	1	2	3	4	5
6. I gained knowledge about the philosophical, legal and ethical trends supporting integration.	1	2	3	4	(SD)

	(SD)	(D)	(U)	(A)	(SA)
7. The workshop provided useful information on the research to support the integration of young children with disabilities into early childhood settings.	1	2	3	4	5
8. I gained knowledge about the importance of the family centered approach.	1	2	3	4	5
9. I gained knowledge about the characteristics of a well-planned.integrated program.	1	2	3	4	5

10. Please identify three of the most significant things you learned as a result of this workshop.

1.

2.

3.

11. What were the strengths of this workshop?

12. In what ways could this workshop be improved?

13. What follow-up needs do you have, if any?

X. TRAINING ACTIVITIES

The following training activities are designed to be used during the first module. For each activity, the trainer has been provided with the purpose of the activity, a description of the activity, the length of time the activity takes, the materials needed, and the recommended audience size for the activity. A different activity may be substituted as long as it meets the intended purposes of the original activity. If the activity is a videotape presentation, a description has been provided of the length of time involved, a summary of the videotape, and potential discussion questions.

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ACTIVITY #1

ICE BREAKER ACTIVITY

Length of Activity

15
minutes

Purpose: To provide participants with an opportunity to introduce themselves to the other participants and to feel more comfortable as part of the larger group.

Description:

A. Two Truths and a Lie

1. Pair individuals with someone who is unfamiliar.

2. Ask participants to tell each other 3 things about their professional or personal lives. Two of the things should be "Truths" and one should be a "Lie". Instruct participants to write down their partners' name and the three things on an index card or Post-it® note.

3. Each person than introduces their partner to the group and places their cards on a wall or bulletin board.

4. Throughout the session, participants should be encouraged to vote for the "lie". Participants should place a mark beside the item on each of the card that they think is a lie. At the end of the day, the real answers are revealed.

B. When I Was A Baby

1. Pair individuals and ask them to talk about their earliest childhood memory.

2. Have each partner introduce each other to the larger group and reveal their earliest memory.

3. Engage the group in a discussion of the common themes revealed by their own experiences and how their memories relate to the world of the young child in general.

Materials:

A. 3x5 index cards and tape or Post-It® notes for each participant

B. No materials necessary

Audience:

Participant pairs and large group sharing

NOTE: *Two different Ice Breaker activities are described below.*

Choose one or substitute a similar activity.

ACTIVITY #2

INTEGRATION QUESTIONNAIRE

Length of Activity

30
minutes

Purpose: To provide participants with an opportunity to reflect upon their attitudes concerning the integration of young children with disabilities and to share their beliefs, ideas, and worries with other participants.

Description:

1. Ask each participant to complete the *Integration Questionnaire*.

2. As a large group discuss some of the answers to the questionnaire. Remind participants that there is no wrong or right answer to any of the questions.

3. Facilitate the discussion by asking questions such as:

   a. Which questions were most difficult to answer and why?

   b. Which questions were the easiest to answer and why?

   c. Did any of your answers surprise you? Why?

4. Ask participants to keep completed questionnaires in their manuals for later comparison.

Additional Strategies:

Materials:

One *Integration Questionnaire* for each participant

Audience:

Individual and large group activity

ACTIVITY #2

HANDOUT: INTEGRATION QUESTIONNAIRE

Date: ____________________

1. **The key reason for integrating young children with and without disabilities is...**

2. **When working with a young child who has a disability, the most critical concerns are...**

3. **The greatest obstacle to successful integration of young children with disabilities into community early childhood programs is...**

4. **Young children react to children with disabilities by...**

ACTIVITY #3

VALUES CLARIFICATION

LENGTH OF ACTIVITY

30 minutes

Materials:

5 index cards per participant, flip chart and markers

Audience:

Individual exercise and large group discussion

Adapted from :

A Values Clarification Exercise. (1990)
Project Copernicus.
The Kennedy Institute,
Baltimore, MD.

Purpose: To assist participants in identifying their own values and to then assist them in identifying the assumptions they may have about families of young children with disabilities

Description:

1. Introduce the purpose of the activity to participants. On a piece of paper, ask participants to individually list the five things that are the most important to them. These are the things that they most value or that are priorities. Give participants 1 -2 minutes to do this.

2. As a large group, generate a list of the values participants have identified.

3. Give each participant 5 index cards. From the generated list, ask participants to identify five values and write one on each card.

4. When completed, tell the group that they are going to have to give up 3 of their values. Have participants put the 3 values they gave up out of reach.

5. As a large group, generate a list of the values that were kept. Keep a tally of the number of participants who kept each value.

6. To summarize the activity ask participants the following discussion questions:

a. Could anyone else have chosen the values you chose today? (Response: only you can determine your values.)

b. Think about the families you work with. Do we respect their values as we want our values to be respected? Do we assume that because they have a family member with special needs, they don't have a right to decide their values for themselves?

c. What do our programs do to support the values of the families we work with?

Additional Strategies:

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

ACTIVITY #1

VIDEOTAPE PRESENTATION: 'NOT IN MY CLASS

LENGTH OF ACTIVITY

40
minutes

10
minutes for discussion

Summary: A dialogue is presented between Dr. Michael Guralnick, a nationally known researcher in preschool mainstreaming, and Eleanore Lewis, a preschool teacher with 20 years of successful mainstreaming experience. Three parents of mainstreamed preschoolers talk about their perspectives on mainstreaming. Margo McMahon, an adult with multiple disabilities, talks about her own early experiences as a "mainstreamed" child.

Questions for Discussion:

1. What are the advantages of a mainstreamed environment for both typically-functioning children and children with disabilities?

2. Is mainstreaming the best solution for all children? Why or why not?

3. What are some of the myths associated with mainstreaming?

4. What are the different models of mainstreaming? Which model is used in your community?

5. What is necessary to ensure successful mainstreaming experiences for **all** of the children involved?

Additional Discussion Questions:

Reference:

Kaiser, C. (1992). *Not in my class: Understanding mainstreaming*. Columbus, OH: Electro Systems, Inc.

ACTIVITY #5

VIDEOTAPE PRESENTATION: TOGETHER WE'RE BETTER

LENGTH OF ACTIVITY

20 *minutes*

Summary: The experience of one Ohio parent and her preschool son with Down syndrome is used as a framework for discussing a number of key issues related to early integration. Examples from other Ohio programs are used to highlight positive practices.

Questions for Discussion:

1. What are some examples of adaptations that preschool staff can use in order to include young children with disabilities in regular preschool programs?

2. What benefits of integration were identified or depicted in the tape?

3. What made integration a positive experience for both Trevor and his mother?

Additional Discussion Questions:

Reference:

Early Integration Training Project (Producer). (1991). *Together We're Better*. (Videotape). Columbus, OH: The Ohio State University, Center for Special Needs Populations.

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

ACTIVITY #6

WHAT DRIVES THE SYSTEM?

LENGTH OF ACTIVITY

30
minutes

Purpose: a. To provide participants with an opportunity to learn the difference between family centered, child centered and service centered delivery systems.

b. To provide participants with an opportunity to discuss some of the issues surrounding the service delivery system in the program or agency where they work.

Materials:

One copy of the handout, *What Drives the System?*, for each participant

One copy of the transparency, *What Drives the System?*

Audience:

Large or small group depending upon the size of the audience

Description:

1. As a large group, or as several small groups, discuss each individual item on the handout.

2. Ask participants to determine whether the item is based on a service delivery system that is system based, child based or family based. Refer participants to their manuals for definitions of each method of service delivery. Record responses on the overhead transparency. Participants should be encouraged to generate discussion on each item. Often the items may have multiple responses depending upon the rationale that is given.

3. After completing the handout, ask each participant to identify ways of providing services in their own program or agency that might by system based, child based, or family based. Family members should be encouraged to discuss the present approaches to service delivery in which they participate. Place responses on an overhead transparency or flip chart that has been divided into three sections: system, child or family. Discuss how system and child centered approaches might become more family centered.

Adapted from :

Recognizing family-centered care: A group exercise. (1990) Project Copernicus. The Kennedy Institute, Baltimore, MD.

Additional Strategies:

44

ACTIVITY #6

HANDOUT: WHAT DRIVES THE SYSTEM?

DIRECTIONS:

For each of the following situations, indicate whetherr it s an example of: a system centered (S), child centered (C), or family centered (F) approach. Some situations may appear to be driven by more than one system. Be prepared to justify your responses

____A complete assessment is done on the child.

____Early intervention services are provided at the facility on Monday through Thursday mornings and home based services are provided on Fridays.

____Occupational therapy sessions are arranged according to the family's schedule.

____Child care is provided for siblings while the child with disabilities receives early intervention services.

____The child care center is open Monday through Friday, 9:00 am - 4:00 pm.

____The local early intervention collaborative group consists of professionals, parents, and representatives from the community.

____The speech therapist comes to the home twice a week for a one hour session with the child.

____An Individualized Family Service Plan, developed by the team of professionals, is given to the parent.

____The social worker arranges for all of the medical equipment for the child ordered by the doctor.

____Transportation to the child care center is available from 9:00 am - 5:00 p.m

____The early interventionist provides the family with a variety of service options that include integration into a regular child care center.

_____A complete assessment is done on the child.

_____Early intervention services are provided at the facility on Monday through Thursday mornings and home based services are provided on Fridays.

_____Occupational therapy sessions are arranged according to the family's schedule.

_____Child care is provided for siblings while the child with disabilities receives early intervention services.

_____The child care center is open Monday through Friday, 9:00 am - 4:00 pm.

_____The local early intervention collaborative group consists of professionals, parents, and representatives from the community.

_____The speech therapist comes to the home twice a week for a one hour session with the child.

_____An Individualized Family Service Plan, developed by the team of professionals, is given to the parent.

_____The social worker arranges for all of the medical equipment for the child ordered by the doctor.

_____Transportation to the child care center is available from 9:00 am - 5:00 p.m

_____The early interventionist provides the family with a variety of service options that include integration into a regular child care center.

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

ACTIVITY #7

VIDEOTAPE PRESENTATION: ICC PARENTS SHARE THEIR STORIES

LENGTH OF ACTIVITY

15 *minutes*

Summary: Four parents who serve on state interagency coordinating councils for early intervention share their families' stories and expectations regarding the creation of family -centered service systems for young children with disabilities.

10 *minutes*

Questions for Discussion:

1. What are some of the important elements of family-centered care?

2. What were the priorities of the parents? Do these differ markedly from the priorities of parents in general?

Additional Discussion Questions:

Reference:

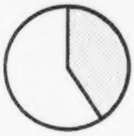
Early Integration Training Project (Producer). (1991). *ICC Parents share their stories* (Videotape). Columbus, OH: The Ohio State University, Center for Special Needs Populations

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

ACTIVITY #8

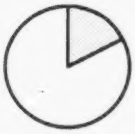
VIDEOTAPE PRESENTATION: ON THE JOURNEY TOGETHER

Length of Activity



25
minutes

Summary: Parents of children with disabilities discuss their experiences with medical professionals and service-providers. Throughout the discussion, positive and valued characteristics of professionals are revealed. Other issues such as changing physicians, getting answers to questions, and forming a team with case managers and other service-providers are also discussed. Advice to new parents of children with disabilities is given by the parents.



10
minutes

Questions for Discussion:

1. What are some of the characteristics of a professional who would work well with parents who have a child with disabilities?

2. What can be dangerous about making predictions regarding a child's future?

3. What are a parent's rights when working with medical and service professionals?

Additional Discussion Questions:

Reference:

Family Network (Producers). (1990). *On this journey together: Parent/Professional Partnership.* New Lexington, OH: The Family Network.

ACTIVITY #9

INTEGRATION PLANNING TOOL

LENGTH OF ACTIVITY

20
minutes

Materials:

Integration Planning Tool for each participant

Audience:

Individual and Large Group

Purpose: a. To help participants identify the characteristics of quality integrated programs in their current programs

b. To help participants plan for ways to increase the quality of their programs.

Description:

1. After discussing each of the "Best Practice" characteristics, ask each participant individually to complete the *Integration Planning Tool*. Ask participants to focus on their different ratings for the two questions (Where are you now? and Where do you want to be?). Family members should be encouraged to use the scale to rate the program or services in which their child participates.

2. As a large group, discuss the responses to each item. Generate discussion by asking questions such as:

a. Were there any differences between where you are now and where you want to be? What is keeping you from being where you want to be?

b. Are any of the quality indicators easier or harder to implement and why?

c. If more than one participant is from the same program, ask them to compare their answers. Were there any differences in responses? What were the differences and why do they exist?

Additional Strategies:

EARLY INTEGRATION TRAINING PROJECT
INTEGRATION PLANNING TOOL

Name:______________________ County:______________________ Date:__________

This tool was designed to help identify individual and programmatic goals for developing integrated early childhood programs. To use the scale, first read all the descriptors then answer the two questions by circling the number that corresponds to the best response. The first question "Where are you now?", relates to your program or agency's current role in the integration of young children with disabilities into early childhood settings. The second question, "Where do you want to be?", asks you to identify where you would like your program or agency to be in the future. **You must circle only one number for each question.** *If you feel that your program falls between two responses, circle the lower number only.*

1. A consistent program philosophy based on knowledge of typical and atypical early childhood development is shared, articulated and implemented by all program participants.

Where are you now? ▶	1 2	3 4	5 6	7 8
	No program philosophy exist.	Existing philosophy is not well-developed and/or shared by **few** participants.	Existing philosophy is fairly well-developed and/or is shared by **some** participants.	Sound, well-developed philosophy exists and is shared by **all** participants.
Where do you want to be? ▶	1 2	3 4	5 6	7 8

Format adapted from: **Bailey, D.**, *FOCAS: Family Orientation of Community and Agency Services*, University of North Carolina at Chapel Hill, Frank Porter Graham Child Development Center.

2. The program promotes the concept of integration, which means that children with and without disabilities share common settings and good relationships.

Where are you now?	1 2	3 4	5 6	7 8
	No opportunities for integration exist.	**Few** opportunities exist for children with disabilities to share settings or develop good relationships with children without disabilities.	**Some** opportunities exist for children with disabilities to share settings or develop good relationships with children without disabilities.	Children with disabilities spend **most** of the day in common settings and in developing good relationships with children without disabilities.
Where do you want to be?	1 2	3 4	5 6	7 8

---

3. The family and staff from all environments in which the child participates have many opportunities for collaborative, comprehensive planning.

Where are you now?	1 2	3 4	5 6	7 8
	No opportunities for planning exist .	**Few** opportunities for planning exist, but they do not include staff from any other program serving the child and family.	**Some** opportunities for planning exist and there are also opportunites to plan collaboratively with staff from other programs serving the child and family.	**Many** opportunities for collaborative planning exist and these often include staff from other programs serving the child and family.
Where do you want to be?	1 2	3 4	5 6	7 8

4. The learning needs of children with disabilities are met through adapting regular activities and materials.

Where are you now?	1 2	3 4	5 6	7 8
	Learning needs of children with disabilities are **never** met through adapting regular activities and materials.	Learning needs of children with disabilities are **rarely** met through adapting regular activities and materials.	Learning needs of children with disabilities are **sometimes** met through adapting regular activities and materials.	Learning needs of children with disabilities are **often** met through adapting regular activities and materials.
Where do you want to be?	1 2	3 4	5 6	7 8

5. Parents are provided multiple opportunities for involvement in their child's program and have a great degree of control in choosing these options.

Where are you now?	1 2	3 4	5 6	7 8
	Parents are **not** offered any opportunities to participate in their child's program.	Parents are offered **few** opportunities to participate in their child's program and have little control in choosing those options.	Parents are offered **some** opportunities to participate in their child's program and have some control in. choosing those options.	Parents are offered **many** opportunities to participate in their child's program and have a great degree of control in choosing those options.
Where do you want to be?	1 2	3 4	5 6	7 8

ACTIVITY #6

BARRIER IDENTIFICATION

LENGTH OF ACTIVITY

30
minutes

Materials:

Post-it® notes or index cards and tape

Audience:

Large group discussion

Purpose: a. To provide participants with an opportunity to discuss potential barriers to providing integrated settings in their own communities.

b. To provide participants with an opportunity to generate potential solutions to identified barriers.

Description:

1. Facilitate a brainstorming discussion of potential barriers to integration.

2. Write each identified barrier on an index card as participants generate them. Tape or fasten each barrier to the wall. If solutions are generated to the barriers, write them down on the appropriate index card.

3. At the end of the session, the trainer should collect the cards for the next session.

4. The trainer may wish to use the following list of potential barriers if participants have difficulty identifying barriers or seem to have difficulty identifying possible key barriers.

5. At the end of the session, the trainer should collect the cards for the next session.

6. The trainer may wish to use the following list of potential barriers if participants have difficulty identifying barriers or seem to miss what might be key barriers.

Additional Strategies:

ACTIVITY #6 BARRIER IDENTIFICATION

A. Personal Barriers: Those barriers that relate specifically to the individuals involved in integrating a young child with disabilities into an early childhood setting. The barriers are related to the staff and the child with disabilities.

1. Attitudes of Staff Concerning Children with Disabilities: Staff may not feel comfortable with the idea of integrating a young child with disabilities into an early childhood setting. Other staff may feel comfortable with some children with disabilities but not with others. Comments such as "He'll be a bad influence on the other children," or "She has too many motor difficulties to be in my classroom," or "He is too disabled to be in that setting," may be a key to identifying these barriers.

2. Attitudes of Staff Concerning Potential Role Changes: Integrating young children with disabilities into early childhood settings may involve role changes for both early childhood educators and support service staff. Some staff may be reluctant to make the changes that will be necessary to insure that the integration of the young child with disabilities is successful.

Changes will have to be made where staff work, how staff work and what staff do with children. These changes may bring out a sense of territorialism in staff that can be a barrier to integration.

3. Qualifications of Staff: Staff may not feel qualified to work with young children with disabilities in integrated settings. This may only be a barrier if the staff is unwilling or unable to develop additional skills and knowledge. Barriers may also occur if staff is unwilling to cross-train in their area of expertise.

B. Programmatic Barriers: Programmatic barriers relate to the setting where the integration is to occur. Barriers to integration may exist due to the building, people who interact with the child with disabilities, and/or with the changes in programming and staffing that may be needed to fully support integration.

1. Physical Plant Barriers: Barriers may exist that limit integration because of the physical structure of the building or classroom. Examples of these barriers include: stairs for a child who is nonambulatory, poor acoustical environments for a child with a hearing impairment or a child who cannot tolerate noise, or lack of adequate lighting for a child with visual impairments.

2. Attitudes of Persons in the Environment Toward Children with Disabilities: Other staff, families, and peers may present barriers to integration if care is not taken to prepare them for the integration of a young child with disabilities. Comments such as "I don't want him in my child's class," may be identified as barriers to integration.

3. Changes in Programming: Changes in the way both early childhood personnel and support service personnel work may be necessary. Although staff may be willing to make these changes, the changes may not be supported by the programs/agencies that provide services to young children with disabilities. Barriers may occur if agencies are not willing to make changes in staffing patterns, roles and responsibilities to meet changes in programming. Barriers may also include funding sources, liability issues and transportation issues.

C. Community Barriers: Other barriers exist that are not under the control of the staff or the program/agency where they work. These barriers relate to the community as a whole. Some of these barriers may include: the rules and regulations of both child care and special education services, including: certification issues, the availability of programs and services, and issues related to liability, funding and transportation at the community level.

XI. OVERHEAD TRANSPARENCIES

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1

Module One: Outline of Training

- What is Integration?
- Philosophical and Legal Trends of Integration
- Research in Support of Integrated Settings
- The Importance of a Family Centered Approach
- Characteristics of a Well-Planned Integrated Program

Module One: Purpose

- To provide information on integration and quality programming for young children with disabilities.

Module One: Goals

- To provide an overview of the positive outcomes which can be expected through well-planned, integrated programs.
- To provide information related to a family centered approach to providing quality programming for young children with disabilities.
- To provide participants with an opportunity to identify barriers to providing well-planned, integrated programs in their community.

4

Module One: Participant & Trainer Expectations

- The Trainer will provide participants with the:
  - information to be able to understand the philosophical and legislative history of integration
  - information to be able to discuss positive aspects of integrated programs
  - opportunity to explore their feelings and values related to the integration
  - information concerning a family centered approach to providing quality programming
  - information to be able to discuss the characteristics of a well-planned, integrated program
  - information to be able to describe local barriers to providing integrated programs

5

Key Themes

- Environments for all learners need to be emotionally secure and physically safe
  - Secure relationships enhance learning
  - Autonomy and decision making abilities support learning
  - Accurate, understandable information enhances the learning environment
  - Within a secure environment we are both teachers and learners

6 Key Themes (cont.)

- Learning can be enhanced through individualization
  - Individualization can and does occur within group settings
  - Social interactions with a variety of peers and adults can enhance learning
- All learners have a variety of strengths and needs
  - You don't need to segregate to teach
  - You don't need to segregate to learn

7 Key Idea: What is Integration & Why Is It Important

- The idea of placing children with disabilities in regular education settings has a long history in the United States. However, the words used to talk about the idea have changed and evolved with the philosophy. The purpose of this section is to describe the terms related to integration and to show how they reflect the movement from mainstreaming to integration to inclusion.

8 Definition of Integration

- Integration is a broad term which refers to the opportunity for the student with disabilities to have access to, inclusion in, and participation in all activities of the total school environment. Effective integration means planning and providing maximal opportunities for interactions between non-disabled students and their peers who have disabilities. These interactions can and should occur in a variety of settings and ways.

(Biklen, Lehr, Searl, & Taylor, 1987, p11).

9

Other Terms Related to Integration

- Normalization
- Least Restrictive Environment (LRE)
- Mainstreaming
- Inclusion

1 Overhead Transparencies

10

Key Idea: Philosophical and Legal Trends

- The integration of individuals with disabilities has a long history in the philosophical, legal and ethical trends that have occurred during the past fifty years. Many people with disabilities have benefited not only from the legislation focused on disabilities, but also from the legislation aimed at civil rights issues.

Philosophical and Legal Trends

- Brown v. Board of Education, Topeka, KS (1954)
- Civil Rights Act (1964)
- Significant State Decisions
  - PARC v. Pennsylvania (1972)
  - Mills v. Bd. of Ed. of the District of Columbia (1972)

1 Overhead Transparencies

12

Philosophical and Legal Trends (cont.)

- Section 504 of the Rehabilitation Act (1973)
- P.L. 94-142, Education of the Handicapped Act (1975)
- P.L. 99-457, The Education of the Handicapped Act Amendments (1986)
- P.L. 101-336, The Americans with Disabilities Act (1990)
- State Legislation in Ohio

13

Legal Milestones

1954 Brown v. Board of Education

1964 Civil Rights Act

1972 PARC Decision
Mills Decision

1973 Section 504

1975 P.L. 94-142

1986 P.L. 99-457

1990 P.L. 101-336

1991 Ohio Services 3-5 year olds begin

14

Key Idea: Research in Support of Integrated Settings

- The philosophical and legal trends toward integration have provided a moral and ethical reason for placement of young children with disabilities into regular early education programs. In addition, the research data on integration has also empirically shown evidence to support providing integrated programs. This evidence has shown the lack of benefits for children in segregated settings and the positive outcomes from participation in integrated programs.

15 Research in Support of Integrated Settings

- Benefits for Young Children with Disabilitites
- Benefits for Families
- Benefits for Nonhandicapped Peers

16

Key Idea: The Importance of a Family Centered Approach

- The family is the primary environment for the young child with disabilities. Services that are most effective for the child with disabilities occur when the family, and not just the individual child is the focus of attention. One of the major purposes of developing a variety of service options in the community is to increase the choices for families and to maximize the potential for family support.

17

Approaches to Service Delivery

- System Centered
- Child Centered
- Family Centered

18

Key Idea: Characteristics of a Well-Planned Integrated Program

- For integrated programs to be effective, they must be well-planned researched-based, and developmentally as well as exceptionality appropriate. The development of an integrated early childhood program takes time, effort, and team work from early childhood professionals, special educators, administrators, and parents of children with and without disabilities. The development of a quality program is an ongoing process that evolves over time.

19

Characteristics of a Well-Planned Integrated Program

- A consistent program philosophy, based on knowledge of typical and atypical early childhood development is shared, articulated and implemented by all program participants.
- The program promotes the concept of integration, which means that children with and without disabilities share common settings and good relationships.

20

Characteristics of a Well-Planned Integrated Program (cont.)

- The family and staff from all environments in which the child participates have many opportunities for collaborative, comprehensive planning.
- The learning needs of children with disabilities are met through adapting regular activities and materials.
- Parents are provided multiple opportunities for involvement in their child's program and have a great degree of control in choosing these options.

21

Field Exercises

- Interview two or more people about their views concerning the integration of children and adults with disabilities into the community.
- Arrange to visit one of the other programs represented in the training group.
- Interview a person with disabilities or a parent of a child with disabilities. What were their experiences with early childhood education? What were their experiences with integration?

Field Exercises (cont.)

- Identify one barrier in your current setting. Think of possible strategies to overcome the barrier.
- Read a local newspaper, magazine, or watch the local news on television. Are there any stories related to integration or persons with disabilities?
- Generate your own ideas.

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

XII. SUMMARY PAPERS

TITLE PAGE

1. EITP Themes: What We Believe and Why We Believe It 101

2. Philosophical and Legal Background to the Concept of Integration . 103

3. Important Legal Milestones Relating to Americans with Disabilities 105

4. LRE for Preschool Children with Handicaps: What We Know and What We Should Be Doing 109

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7. Fostering Friendships 127

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

WHAT WE BELIEVE AND WHY WE BELIEVE IT

Mary T. Anketell

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The Early Integration Training Project (EITP) has identified several keys themes that guide the content and the activities presented throughout the training modules. These key themes are identified in the introduction and are repeated in each module. The overall purpose of the themes is to help participants to identify the beliefs that are promoted in the modules. The themes relate both to the young learner in an early childhood setting and to the adult learner in the training sessions. This paper will describe each of the themes as they relate to the philosophy of the EITP and the training modules.

☆ Environments for all learners need to be emotionally secure and physically safe.

- Secure relationships enhance learning
- Accurate, understandable information enhances the learning environment
- Within a secure learning environment we are both teachers and learners
- Autonomy and decision making abilities support learning

Learning is a process that involves taking some risks. The learner is put in a position where aspects of his/her world are unknown and some experimentation is necessary to determine how the world functions. This can be a very unsettling process unless the learning environment supports the learner. Therefore, the creation of environments that are emotionally secure and physically safe is an essential component of designing learning environments for both adult and child learners. Secure personal relationships and accurate, understandable information can enhance the feeling of safety in a learning environment. Within this type of secure learning environment, there is an opportunity to learn from each other. Educators assist the learner in the learning process, but also are able to learn a great deal from the learner.

Within a secure environment, learning can be further enhanced by allowing learners to have some autonomy and some ability to make decisions. This is often difficult for the educator to realize because of the outside constraints of times and schedules When teaching children, it is too easy to create a learning environment that does not allow for child to have input into the types or timing of learning activities. In a similar manner, when teaching adults, care must be taken to insure that the participants have an opportunity to help determine content, timing, the style of the presentation.

☆ Learning can be enhanced through individualization

- *Individualization already occurs within group settings*
- Individualization in group settings can be enhanced

Learning can also be enhanced through the individualization of teaching style, presentation and content. Teachers already make these individualized adaptations, although they may do them unconsciously. For example, adaptations are quickly made for the one child in a group who appears to be having difficulty staying in his/her area during a story activity. The child may be allowed to assist the teacher in getting another book to be read or may help in passing out materials for the activity. In a similar manner, adaptations are made for adults who may have different backgrounds or experiences by giving the adult participants examples that relate the content specifically to their needs.

The key to enhancing learning is for the teacher to begin to consciously identify the adaptations they are already making and to consciously plan for others that may be needed. By planning for individual needs, the teacher can be more effective in enhancing the learners ability to learn.

☆ All learners have a variety of strengths and needs

- You don't need to segregate to teach
- You don't need to segregate to learn
- Social interactions with a variety of peers and adults can enhance learning.

Every adult and child learner, regardless of whether there is a label of a disability or not, brings individual strengths and needs to an educational environment. The role of the educator therefore, is to identify individual strengths and use them to impact on areas of need. Since all learners have strengths and needs, there is no need to segregated by perceived weaknesses in order to teach. This theme is the key idea behind the movement toward integrating young children with disabilities into regular early childhood settings.

This theme also relates to the adult learners who are participating in the EITP training. The training is provided to all adults who are involved with the integration of young children with disabilities. Separate sessions are not run for early childhood specialist vs. special educators. Grouping all participants together, will provide an opportunity for the participants to learn from the strengths of the other participants. In a similar manner, young children without disabilities can benefit from the integration of young children with disabilities.

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

PHILOSOPHICAL AND LEGAL BACKGROUND TO THE CONCEPT OF INTEGRATION

Dennis Sykes

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The philosophical and legal traditions related to the integration of individuals with disabilities into the larger society are closely intertwined. While the 1954 supreme court decision in *Brown v. Board of Education* was directly related

The philosophical and legal traditions related to the integration of individuals with disabilities into the larger society are closely intertwined. While the 1954 supreme court decision in *Brown v. Board of Education* was directly related to racial segregation, it set a precedent which was applied, philosophically, to the needs of many minority groups. The language utilized in the decision is interpreted by many to be applicable, philosophically if not legally, to the issue of the segregation of the disabled. Chief Justice Early Warren wrote in 1954 that:

> *Separate educational facilities are inherently unequal. This inherent inequality stems from the stigma created by purposeful segregation which generates a feeling of inferiority that may affect their hearts and minds in a way unlikely ever to be undone.*

While this sentiment was being broadly applied to the issues of societal racial segregation in the 1960s and expressed itself legally in the Civil Rights Act of 1964, other trends were affecting its application to the population of Americans with disabilities. The concept of normalization was imported from Scandinavia through the efforts of Gunnar and Rosemary Dybwad and Wolf Wolfsenberger. This concept basically stated that individuals with disabilities should experience ..."patterns of life and conditions of every day living which are as close as possible to the regular ways of life of their society." The reality of 1960s America was far from this goal, nonetheless, both theory and practice began to accommodate this vision, not without a bit of prodding from the legal system.

The public educational system was the target of two key court decisions in the early 1970s. Both *Pennsylvania Association for Retarded Citizens (PARC) v. Commonwealth of Pennsylvania* and *Mills v. Board of Education* ratified the right of children with disabilities to a public education. The intent of these decisions was ratified on the federal level by the Education for All Handicapped Children Act (Public Law 94-142) in 1975 which followed soon after the passage of Section 504 of the Rehabilitation Act of 1973. The combination of these acts forbade discrimination, on the basis of handicap, in federally funded programs and in public schools.

In particular, P.L. 94-142 states that...

> *to the maximum extent appropriate, handicapped children in public and private institutions or other care facilities, are educated with children who are not handicapped, and that special classes, separate schooling, or other removal of handicapped children from the regular educational environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily...*

The above statute was interpreted in regulation as the necessity for serving children with disabilities in the "least restrictive environment" (LRE) which is interpreted legally as meaning that the state must do things in a manner that least intrudes upon (restricts) individual rights. While important, this concept has been vague enough to be interpreted in a variety of ways.

The passage of Public Law 99-457 in 1986 served to focus national attention on services to children with disabilities, birth through 5. This law provides 2 separate initiatives for the birth through 2, and 3-5 populations. It mandates the requirements of P.L 94-142 for the 3-5 population and provides a new, voluntary program for the infant and toddler population. Both initiatives express a strong preference for integrated settings. The 3-5 federal regulations require complete compliance with the LRE provisions of P.L. 94-142 and in addition:

> *...Public agencies that do not operate programs for non-handicapped preschool children are not required to initiate such programs solely to satisfy the requirements regarding placement in the least restrictive environment embodied in 300.550 through 300.556. For these public agencies, some alternative methods for meeting the requirements of 300.550 through 300.556 include:*
>
> *(1) Providing opportunities for the participation (even part-time) of preschool handicapped children in other preschool programs operated by public agencies (such as Head Start);*
>
> *(2) Placing handicapped children in private school programs for non-handicapped preschool children or private school programs that integrate handicapped and non-handicapped children; and,*
>
> *(3) Locating classes for handicapped preschool children in regular elementary schools.*
> *In each case, the public agency must ensure that each child's placement is in the least restrictive environment in which the unique needs of that child can be met, based upon each child's individualized education program, and meets all of the other requirements of 300.349 and 300.550 through 300.556.*
> Federal Register, *April 27, 1989*
>
> *The infant and toddler regulations concerning integration are extremely succinct.*
> *303.12 Early Intervention Services*
> *(iv) (4) (b)* Location of Services. *To the extent appropriate, early intervention services must be provided in the types of settings in which infants and toddlers without handicaps would participate.*
> Federal Register, *June 22, 1989*

While the above regulations state a preference for integration, there remains considerable room for interpretation. The philosophical arguments remain the best justification for integrated programs. Programs which prepare children for lives in a wider world and promote normal experiences require integration. The endeavor to change attitudes about individuals with disabilities in the larger community has little chance if those individuals are "out of sight, out of mind."

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

IMPORTANT LEGAL MILESTONES RELATING TO AMERICANS WITH DISABILITIES

Dennis Sykes

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***Brown v. Board of Education* of Topeka, Kansas** (347 US 483 1954)

This U.S. Supreme Court decision involved a compilation of 12 cases. It was significant in that it provided for the first time that education was a basic right subject to equal protection under the 14th Amendment to the U.S. Constitution. This was revolutionary as education is not a constitutionally a federal function but, rather, is delegated to the states. The decision set the stage for a veritable avalanche of legal challenges to various state and local laws throughout the late 50s, 60s, and into the 70s. Though the case dealt specifically with educational segregation by race, in many ways it marked the beginning of the general Civil Rights movement and established the important precedent that "separate is not equal." This overturned long-held legal precedents which maintained the opposite.

The Civil Rights Act of 1964

This federal legislation broadly prohibited discrimination on the basis of race in a variety of public and private enterprises. It attempted to implement the notions of "equal opportunity" and "separate is not equal" as it applied to employment, housing, etc. on a national level. It lead to a variety of legal confrontations between the federal and state/local governments.

PARC v. Pennsylvania, 344 F. Supp. 1257 (E.D. Pa. 1971), amended settlement approved, 343 *F. Supp*. 279 (1972) was a class action suit was brought by the Pennsylvania Association for Retarded Citizens (PARC) against the Commonwealth of Pennsylvania on behalf of children with mental retardation who were excluded from public education because of their disability. Jurisdiction of the federal court was established utilizing, again, the 14th Amendment. A consent decree was developed by the state-level federal court as the Commonwealth decided not to contest the suit. Important principles such as: "free, appropriate public education;" least restrictive environment;" and parental participation in decision making were outlined and later utilized as the framework for P.L. 94-142.

A related case is *Mills v. Board of Education*, 348 *F. Supp*. 866 (D.D.C. 1972). The case was brought on behalf of 7 students with a variety of disabilities who were being denied a public education. It was significant in that it involved the Board of Education of the District of Columbia and, as such, the 14th Amendment could not be invoked. As an alternative, the federal court utilized the due process provisions of the 5th Amendment thus broadening the precedent. Other important principles established in this case were: "zero reject", right to due process, and the right to a "free, suitable public education."

Section 504 of the Rehabilitation Act of 1973

This federal legislation prohibited discrimination in on the basis of handicap in programs receiving federal financial assistance. It often is related to employment practices, but can apply to any service provided by a program receiving any federal funds.

Public Law 94-142, The Education of the Handicapped Act

The Education of the Handicapped Act was passed by the U.S. Congress in 1975 and states began its implementation in the fall of 1978. This federal legislation sought to implement the various state decisions such as PARC and others as the "law of the land." The principles of "zero-reject, child-find, least restrictive environment, non-discriminatory testing, due process, and parent participation were taken from the PARC, Mills and related decisions. In addition, the Congress added provisions for the individualized educational plan (IEP). The law uses a funding incentive to encourage state participation. The state of New Mexico was the last state to choose to participate and did so in the mid-1980s.

In particular, P.L. 94-142 states that...

> *to the maximum extent appropriate, handicapped children in public and private institutions or other care facilities, are educated with children who are not handicapped, and that special classes, separate schooling, or other removal of handicapped children from the regular educational environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.*

The above statute was interpreted in regulations as the necessity for serving children with disabilities in the least restrictive environment. This is interpreted legally as meaning that the state must do things in a manner that least intrudes upon (restricts) individual rights. While important, this concept has been vague enough to be interpreted in a variety of ways.

The 1990 reauthorization of the Education of the Handicapped Act changed the name of the legislation to the Individuals with Disabilities Education Act (IDEA).

Public Law 99-457,
The Education of the Handicapped Act Amendments of 1986

Public Law 99-457 was passed by the U.S. Congress in October of 1986. It amended Public Law 94-142 to mandate services to age 3 by school year 1991-92 under Part B of the original act. It also implemented financial incentives for serving new children, and financial sanctions (loss of all federal preschool funds under the act) for states not complying by the deadline. It also created a **voluntary** program for infants and toddlers (birth through age two) with developmental delays or "at risk" of becoming developmentally delayed. This program was given a five year implementation timeline dating from the point of a state's entry. All states and territories chose to enter the program in its first year of availability (1987) and are currently completing their third year of implementation.

Both the 0-2 and 3-5 year old initiatives express a strong preference for integrated settings. "To the extent appropriate, early intervention services must be provided in the types of settings in which infants and toddlers without handicaps would participate" (Federal Register, June 22, 1989). The 3-5 year old federal regulations require complete compliance with the LRE provisions of P.L. 94-142 and suggests alternative methods for meeting these provisions including:

- Providing opportunities for the participation (even part-time) of preschool handicapped children in other preschool programs operated by public agencies (such as Head Start);
- Placing handicapped children in private school programs for non-handicapped preschool children or private school programs that integrate handicapped and non-handicapped children; and
- Locating classes for handicapped preschool children in regular elementary schools.

While the above regulations state a preference for integration, considerable room for interpretation remains. The philosophical arguments remain the best justification for integrated programs. Programs which prepare children for lives in a wider world and promote normal experiences require integration. The endeavor to change attitudes about individuals with disabilities in the larger community has little chance if those individuals are "out of sight, out of mind."

The Americans with Disabilities Act of 1990

This federal legislation was passed by overwhelming majorities in the U.S. Congress in the spring of 1990. It extends broad protections related to employment, housing, transportation, and telecommunications. to all Americans with disabilities. Importantly, the legislation extends its reach to the private, as well as the public sector. Previous legislation dealt only with programs receiving federal funding. Most aspects of this legislation will become effective in 1992.

1 MODULE

WHAT IS INTEGRATION & WHY IS IT IMPORTANT?

LRE FOR PRESCHOOL CHILDREN WITH HANDICAPS: WHAT WE KNOW, WHAT WE SHOULD BE DOING

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Reprinted with permission from:

Strain, P. (1988). LRE for Preschool Children with Handicaps: What we know, what we should be doing. In D. Sykes (Ed.), *Conference Proceedings of the Planner's Conference on Integration and the Least Restrictive Environment for Young Children* (pp. 46- 55). Columbus, OH: Great Lakes Area Regional Resource Center.

WHAT WE KNOW

LRE for preschool-age children with handicaps has gained national attention with the passage of Public Law 99-457 in 1986. P.L. 99-457 addresses the least restrictive environment (LRE) question by extending the provisions of P.L. 94-142 to children three Years of age and older. While we might well expect to see challenges to the LRE language in P.L. 99-457, the importance of integrated services for young children with handicaps is not in doubt. Over the last 10 Years, the evidence regarding integrated service delivery for young children with handicaps has accumulated rapidly. **What we know** at this point, on the basis of scientific evidence, is that:

☆ One of the things that parents of young children with handicaps most desire is for their youngsters to develop friendships with same-age peers.

☆ No study that has assessed social outcomes for children in integrated versus segregated settings has found segregated settings to be superior.

☆ If we ask the question, "What developmental outcomes are most likely to lead to successful post-school adjustment," social skills is always the answer.

☆ The positive social outcomes attributable to integrated settings have been seen **only** when interaction is frequent, planned, and carefully promoted by teachers.

☆ Normally developing children have shown **only** positive developmental and attitudinal outcomes from integrated experiences.

☆ There is **no** evidence that children with certain handicapping conditions or levels of impairment are poor candidates for integrated programs.

☆ On measures of how well children maintain skills after some initial teaching, developmentally segregated settings have been shown to have a toxic effect (i.e., children no longer use their newly-taught skills).

☆ Programs that are characterized by integrated service delivery tend to be state-of-the-art on a variety of other dimensions, including extensive parental involvement, highly structured scope, sequence, and method of instruction, and attention to repeated outcome assessment.

WHAT WE SHOULD BE DOING

Given the empirical findings described above, it is reasonable to ask how we might translate this information into an ongoing service delivery model. In this regard, the empirical findings speak to the following programmatic issues: a) child referral to integrated settings; b) continuum of services; c) teacher training; d) class organization and structure; and, e) administrative practices.

Child Referral.

There is great intuitive appeal to the notion that less handicapped children are better candidates for integrated service delivery than more involved youngsters. However, this is a case where intuition is not supported by science. By and large, we have a case of missing evidence; and what evidence there is does not support the intuition. From a policy and procedure standpoint, we must recognize that there are no available data upon which to exclude children from integrated placements. There are also demonstrations of successful integration with severely handicapped children. Based upon the evidence to date, we should only screen children away from maximally integrated options after those high quality options have been tried and after they have failed.

Continuum of Services.

P.L. 94-142 has essentially promoted the evolution of a working definition of LRE that is best described as a continuum of service, with points on the continuum ranging, for example, from segregated class in segregated building, to segregated class in regular building, to regular class in regular building. Depending on the IEP, various points along the continuum can meet the **legal requirements** of the LRE provision. For preschool children with handicaps, our policy and procedures on LRE must begin with matching the "working" continuum with the scientific evidence. When we do that, the range of options that lead to positive outcomes is severely narrowed. Specifically, we only have evidence that integrated services produce the outcomes we desire when young children with handicaps are integrated at least several days per week into the social and instructional environment with normally developing peers. From a policy and procedure standpoint we may be faced with not so much a continuum but a dilemma. The dilemma being that LRE requirements may be bureaucratically satisfied with a service option that is benign or possibly harmful to our clients.

Teacher Training.

One need only review the dates in the resource section at the end of this paper to see that the technology and tactics for operating high quality integrated programs is **very new.** If we further consider that the bulk of this technology is contained in research papers, then it is fair to assume that most direct service providers require intensive, competency-based preservice and inservice experiences related to LRE. The successful teachers in LRE arrangements will be those who, at a minimum, know how to:

1. Assess the current educational and social needs of all children and plan instruction accordingly;

2. Meet the individual goals of all children within a group teaching format;

3. Plan and arrange for daily interactions between children;

4. Utilize class peers as instructional agents;

5. Frequently monitor child outcomes and modify instructional procedures, if necessary:

6. Communicate effectively with parents and enlist their help, where needed; and

7. Plan for child and family transition to the next educational setting.

For integrated service delivery to fulfill its potential, it seems clear that a much greater emphasis on teacher preparation is needed. Attempting innovations like integrated service delivery with less than the best prepared staff will likely yield poor services, poor outcomes, and ultimately less integration for children with handicaps.

Classroom Organization and Structure.

As noted earlier, programs that have been characterized by high quality integration and excellent child outcomes have also been state-of-the-art on a variety of other dimensions. In order to fully realize the potential of integrated service delivery, programs for young children with handicaps should include:

1. Provisions for early screening, referral, and programming to ensure a minimal time delay between problem development and intervention;

2. Provisions for the assessment of family strengths, weaknesses, and skill needs; and, intervention that is planned accordingly;

3. Provisions for repeated curriculum-based assessments and instruction that is related directly to said assessments; and

4. Provisions for overall program evaluations that include the opinions of consumers (e.g., parents, teachers, administrators).

From a policy and procedure standpoint, the institutionalization of quality service delivery will require that we certify educational practices, not merely personnel. We can do this by developing new program standards and scrupulously monitoring, providing technical assistance and training for deficient programs and personnel, and de-certifying programs and personnel that are chronically deficient.

Administrative Practices.

Any educational innovation, be it preschool integration or otherwise, will have **little** hope for long-term success without the support and vigilance of competent administrators. The administrative-level practices needed to ensure high quality integrated services include:

1. Eliminating, where needed, **state and local** policies that promote disincentives to integration;

2. Providing personnel, time, and fiscal resources needed for necessary teacher training;

3. Expanding options for service delivery and teacher arrangements to include, for example, team teaching and consulting models; and

4. Providing professional leadership by encouraging innovative options for integrating children with handicaps, and providing specific incentives for other administrators to promote integrated service delivery.

LRE RESOURCE MATERIALS:

BACKGROUND AND RATIONALE FOR LRE

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QUALITY INDICATORS OF INTEGRATION IN EARLY CHILDHOOD SETTINGS

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P.L. 99-457, Final Part H Regulations mandate that "To the extent appropriate, early intervention services must be provided in the types of settings in which infants and toddlers without handicaps would participate" (Federal Registrar, 303.12, Early Intervention Services, (IV)(4)(b) Location of Services). Thus quality indicators of early childhood programs providing integrated services must include both developmentally and exceptionality appropriate components.

The National Association for the Education of Young Children (NAEYC) Position Statement concludes "that a high quality early childhood program provides a safe and nurturing environment that promotes the physical, social, emotional, and cognitive development of young children while responding to the needs of the family." A quality program must provide both "age appropriate" and "individually appropriate" services. This practice allows for an environment and experiences that appropriately meet the physical, emotional, social and cognitive needs of the young consumers. NAEYC also purports that each child is a unique individual with their own developmental timetable for learning and that children represent a variety of past experiences and family backgrounds. Additionally, the learning environment including materials and interactions should appropriately reflect the individuality that each child presents.

Developmentally appropriate practices according to NAEYC include a comprehensive curriculum focusing on all areas of child development, effective planning based on appropriate teacher observations and analysis of child needs, and an interactive learning scheme rather than an adult directed teaching approach. In addition, NAEYC purports that materials and activities need to be "concrete, real, and relevant to the lives of young children," and that the program should be able to address atypical interests, skills and abilities.

The integration of young children with disabilities into child care settings for typically developing children should not imply that all children should be treated identically and that a goal for one child is always appropriate for another child. Safford (1989) states that it is inappropriate for the adults caring for the young child with a disability in an integrated environment to "pretend that the disability does not exist." All children provide a uniqueness which is comprised of many components. Children with a disability may manifest characteristics which are associated with the disability; however, many additional components common to all young children also exist. In providing appropriate child care services to young children with disabilities, it may be necessary to provide additional or modified services to facilitate optimal growth and development. A young child with a disability may require services and materials that are individually determined and designed but within the context of a typical early childhood setting and through an interactive versus directive mode of instruction.

Parental rights and responsibilities regarding the care and education of their young children are strongly supported by NAEYC and mandated by P.L. 99-457. Parents should be encouraged to observe and actively participate in their child's programming. Lines of program and home communication should be established and maintained for sharing information on child progress as well as general child development knowledge, insights and resources. Communication and program development may also involve representatives from additional agencies and programs that assist the families and their young children. It is important that comprehensive planning exist and that the plan of intervention be shared and supported by all individuals/programs providing services to the child with disabilities and their families.

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CREATING A VISION AND MAKING IT WORK

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Much has been written about visions. the visions some people have are a bit frightening and can make those listening roll their eyes and mutter about the visionary's grip on reality. But I want you all to put aside those thoughts and imagine, or envision, a totally integrated society. This society would have everyone, regardless of ability, naturally included in all areas. No, don't sit and stop yourself from imagining. Don't say, "How?" or "We can't afford this!" or "Our policy isn't conducive." Just think hard about a totally integrated society. Add detail after detail until this vision looks real in your imagination. When doubts arise, add a specific detail to make it more real. This, then, becomes a driving force which makes that vision a reality. This is what I used in the face of impossible odds regarding the integration of my son Aaron into kindergarten. It worked for me. I hope you can make your visions into reality, too.

My husband Ben and I live in Madison, Wisconsin with our children Adam, 11, and Aaron, 8. I'm opening a window into our family so you can understand why it is critical to look at the whole family. The experiences thrust upon me ever since my son Aaron was born have changed me drastically. So often I've been dragged through them mentally kicking and screaming, "No, No, Not again! Not me! I can't stand this " But, like it or not, my life most certainly will remain anything but dull because of the birth of my second child, Aaron Stephen Brown. Often I find myself lulled into a false sense of normalcy and think our family is like everyone else's - until I tell someone who asks what's entailed in getting up and going or what's involved with getting ready for bed. Or how about an illness? No, the Browns are marching to the beat of a different drummer. Mostly I listen and smile when others talk about their families - -or ask a couple pertinent questions. I used to envy what seemed so normal but now it seems that normal is in the eye of the beholder. It just isn't worth worrying about someone else's life. I know people don't envy me. And, so, occasionally I allow a wistful sigh to escape my lips with a whisper of, "I wonder what it would be like if..." and then I shake my head and say, "Nah. Don't even think about it."

I have dreams to be sure. It took me awhile to get them back but I have them. And they are tempered with a strong sense of reality. They are ambitious, too. And they are driven by my vision that we are all citizens of the world and every one has the right to participate in his or her neighborhood, community, city, state or nation, regardless of his level of ability, to his/her fullest potential.

1 Summary Papers

No one, unless they're a criminal, should have to earn his way into a less restrictive environment. It is our obligation as a society to figure out ways to make this happen and not give excuses as to why it can't.

I didn't use to feel this way. In fact, I rarely even considered the possibility of integration vs. segregation. Of course, in the civil rights movement I was vigorous in stating that all people, regardless of color, should participate in every aspect of our society, but it never struck me that the issue was broader than race alone. I just never thought of people with disabilities, let alone what rights they weren't receiving. I rarely saw a person with disabilities, especially a child, in my daily societal activities. And then, Aaron was born.

Aaron will be eight in January. Aaron attends our neighborhood elementary school. He's in a regular first grade class with supports from an OT, PT, speech, nursing, specialists for the hearing impaired, teacher of the physically handicapped,special transportation and consultation from an expert in the visually impaired. The school he attends is inaccessible and he is transported from floor to floor by a machine called a Stair Trac. This year is incredible in its swings from very positive to down in the dumps. It's been full of challenges, and I'm sure will continue to be so. I'd like to come back to this year later. First I'll give a little history of our involvement with programming for Aaron over the past seven years so you can get an idea where I'm coming from. So, if you'll go back in time with me, I'll show a little of our family's story so you can see how my vision for Aaron evolved over the years. I'm not ungrateful for what we had or have but feel it has to change to truly meet children's and their families' needs. Perhaps you know or will know families like ours as technology enables more children like Aaron to survive and grow up in our communities.

Aaron arrived in January of 1981, January 11th to be exact. He was due on April 16th. We certainly weren't prepared for an emergency Caesarian section so early in my pregnancy but due to a possible infection after premature rupture of my membranes, an emergency C-section was the order of the day–actually it was 3 a.m. On the medical summary I read it described Aaron's condition as limp and blue. Heart massage was done, 100% oxygen was given and my tiny frail son was intubated and whisked off to the Intensive Care Unit. Apgar scores were 1 and 2.

I had never dreamed that there was another nursery that existed alongside those regular ones with orderly rows of tiny beds sporting their pink or blue blankets and serene nurses moving slowly about, doing regular baby-type chores. This wasn't where Aaron went. Aaron's nursery was glaring with bright lights. Machines whistled and beeped. Monitors read out graphs and numbers. Nurses and doctors moved feverishly, lips pursed and frowns lingering all over their faces. And there was Aaron in the middle of a table-like bed with lamps over it, covered by wires and tubes, supported by a ventilator, looking brown, tiny-at 2 lbs.. 3 oz., and totally unlike any baby I'd ever seen. My first words when I saw him were, "He's dead. You're lying about his being alive. Get me out of here." It was a heck of a way to start a relationship. Thank goodness it improved.

The only way to understand and cope with the constant emotional upheaval was to get savvy about his medical procedures. These were Aaron's reality and how progress was measured. And so, we got savvy just to try to make sense of our new life. Looking back I'm so glad I had a chance to be crazy and young and carefree before Aaron's birth. I'm so fortunate that I tried to do some interesting and daring things before we became parents and I'm especially happy I relished every moment of my son Adam's infancy and immersed myself in his childhood until he was 3 1/2 years old. Because once Aaron came into our lives and his needs were not only great but monumental, our lives would have very little resemblance to anything it had been before. We had to do a lot of changing and when I think how young some parents are in similar situations I wonder how they can cope.

In any event, after over 3 months in the hospital, Aaron come home. He was on no machines, he was breast feeding, he weighed 4 lbs. 7 oz.. and the hospital staff said he was acting like "a typical preemie." And we thought that meant he was A-Ok. Somehow a miracle had occurred. He was fine. We could be a regular family again.

We were so very wrong in our assumptions.

Aaron grew and thrived at home. He seemed happy about all that was going on around him. But, two things became clear right away--he threw up a lot and we noticed he was developing an unusual startle response at around six months of age. That startle can be described like this: once he began to react to something he kept on reacting and couldn't "rein himself back in" without physical help. At first I thought it might be a seizure but he didn't seem to lose focus or appear blank so I didn't know what was happening. Both these issues were brought up time and time again at the millions of hours spent in various clinics--at least it seemed like millions. The medical professionals said he'd outgrow the vomiting and they said little at first about the startle but finally said we should make an appointment in the neurology clinic. One physician also recommended we get Aaron's hearing checked because he was at risk for being hearing impaired due to severe jaundice and various drugs used to keep his lungs open.

And so, at eight months Aaron was tested and diagnosed as having a severe to profound bilateral sensori-neural hearing loss. It wasn't what I wanted to hear but I don't remember feeling overly anxious about it. Being the chatter box I was, and still am, I knew I'd keep on yakking regardless.

Less than a month later I was alone with Aaron in the neurology clinic. My husband was out of town and Adam was at a baby-sitter. Aaron and I had waited 1 1/2 hours to be seen and finally went into a room where a resident examined Aaron for ten minutes and, while I stood holding him in the middle of the room, said this, "Well, Mrs. Brown, this is what I see. He's spastic quadriplegia cerebral palsy. He'll never walk, never talk and probably is severely retarded." As the words sank in the world around me began closing inward and I felt as if I were numb and tingling. I couldn't talk. I couldn't think. I didn't know what to do, so I stood and cried. Whereupon he patted my shoulder and said, "Oh, I'm sorry Mrs. Brown. I thought you expected this. I'll get another doctor to confirm the diagnosis." And he left us standing in the middle of a room that seemed both large and small and suddenly extremely nauseating.

How I got home that day, I don't know. And even though I wasn't totally sure of what all those words meant, I knew it was horrible and I dreaded seeing how Aaron would be when he grew up. "Will he drool all the time?", I'd ask Ben. "Will he grimace and look so gross that people will always stare?" I was sure I'd never be able to handle the horrified looks on people's faces--or the buckets of pity.

What will become of us, I'd often cry. But, the most vehement cries from my lips were, "Why me? I can't do this." I hated Aaron for surviving. I hated him for letting us down by being disabled. And, I didn't have any idea of where to turn for comfort.

And this was my state when we called Madison Metropolitan School District to attempt getting Early Intervention Services. It wasn't my idea, it was Ben's because of his Special Ed background. He said the programs were designed to help kids like Aaron get a head start on skills and that Madison had good programs. I could have cared less. I was too numb and scared and bitter to do anything but I didn't want to hold Aaron back (guilt feelings were running rampant) so I reluctantly went along with opening the door to the parade of professionals. Even though most people were kind and tried to be supportive I could see that they'd often get antsy when I'd try to talk about some of my feelings. And so often it seemed that each individual professional would focus on a piece of Aaron that was wrong or needed fixing so that he was lots of pieces that just wouldn't really come together to work in any way that was useful. I was going to doctor's appointments constantly, visiting clinics to get OT or PT or hearing aids or ear molds or I was driving to a school during specific 45 minute time slots to have Aaron have time with special teachers for the Hearing Impaired. And when I wasn't doing that –dragging Adam along, too (Funny, I don't remember much of his growth during this time) professionals with expertise in feeding, hearing, PT and OT were also coming to my house. And I just kept wondering how I'd ever be a mother to Aaron when I couldn't possibly maximize his potential to its greatest–there just weren't enough hours in the day. So the resentment grew toward Aaron and I became more angry and bitter. Because, you see, the equipment and gas for trips and special foods began to mount up in cost and we just couldn't seem to stretch our budget any further. Funding sources we were sent to were a bust because, "we made too much money." The message I got from this was, "Its all your fault and you just aren't managing your finances well enough." This just strengthened my feelings of inadequacy.

At about 15 or 16 months of age, Aaron's health began to slide. He missed lots of school. Vomiting was still a severe problem and it seemed to accelerate. Weight loss or no gain began to occur and Aaron looked wasted and tired a great deal of the time. I remember his sleeping through the night very rarely during the first two years of his life. The words "failure to thrive" began occurring on reports. My fault, again, I concluded. I can't even feed my own child!

After a month-long battle with a flu-like illness in November of 1982 (Aaron was almost 2 years old) I looked at Aaron and saw a hollow-eyed child who was listless and losing ground. I became frightened because I was certain all my resentment toward him was going to culminate in his death. And I suddenly realized that I hadn't given him a chance to be himself, no matter what that would be. I woke up and pledged I'd change and be a real mom. I demanded from physicians that they find out what was wrong with him. They hospitalized him and did a barium swallow which showed he had an esophageal reflex. Surgery was done and a gastrostomy tube was placed.

What these events did for me was to make me realize that physicians definitely didn't know everything. Saying to me that he'd outgrow vomiting for two years was ridiculous. I began, ever so slowly to gain confidence in asserting what I knew. That was good–but the "new" Mom I became was ridiculous.

I threw myself into parenting and supporting Aaron's every need. I tried to carry through on everything every professional at school would say Aaron needed to maximize his potential. You see, even though I thought doctors didn't know Aaron I still thought teachers knew best and it was my job to agree with them and leave goals up to them. So I always did. I signed papers without ever asking what an M-team or IEP was. They wrote goals, I signed off. I rejected offers for respite because, after all, no one could take care of Aaron as well as me.

And all the while, stress from lack of supports, breaks, and financial burdens were eating away at our family. I didn't know what to do or where to turn. We continued being rejected for financial help because of our middle-class income.

And then Aaron's health changed again. He began missing school extremely often again because a simple cold became a nightmare. Aaron's g-tube made him grow, yes, but a cold would come on, he wouldn't cough at all and fill up with secretions and lapse into unconsciousness during the night. I'd find him, couldn't awaken him, would call the ambulance and we'd rush to the hospital. Over the course of a year we repeated this procedure six or seven times. Two times Aaron was so bad I didn't think we'd make it to the hospital on time. Once an IV had to be started in his jugular vein because veins in all his extremities were shut down. I got so good at predicting that a bout of distress was coming on that I'd take Aaron to the clinic before it did and say that he was getting sick and was going to be in the hospital very soon unless they could do something to prevent it. They never did, citing that clinically there was no reason to hospitalize him. You see, HMOs were coming into vogue and unnecessary hospitalizations were frowned upon. In any event, during this year of respiratory problems, I tried to go back to work because our family just couldn't make ends meet. But it was a disaster with Aaron getting sick at day care and school and having to go into the hospital. I quit my job after 1 1/2 months because I couldn't stand to leave him in the hospital crying and afraid and wondering how he'd gotten there. I didn't know how we'd do it, but we had to figure out another way. The doctors finally decided, after a year, to remove Aaron's adenoids and then a week later to do a tracheotomy. My pediatrician was against it but pulmonary docs and the head doctor of the ICU felt they had no choice or we'd continue the same routine we'd had over the last year. I felt so desperate I was ready to try ANYTHING but I had no idea how I'd react when I saw the tiny white tube protruding from Aaron's neck. In spite of the fact that Aaron took to his new open airway very well, I saw it as a frightening and disgusting addition to him. In fact, I felt certain he would have to go into an institution because I would never feel comfortable with suctioning, sterile procedures and the ton of equipment which accompanied the tracheotomy. But, try as I might, I just couldn't do it, and dug down into my reserves deeper saying I'd figure out something. Aaron was three years old and our family felt as if it had already lived a lifetime.

And, finally, help came. During the 1 1/2 months of my attempt at working, I had met the director of a new pilot program, The Family Support Program. I had continued on her advisory board even after resigning because she asked me and I thought the Program sounded WONDERFUL.

One day she called me right after Aaron got his trach and asked me how I was and how I was doing. "Oh, I'm fine, Anne," I replied. "I'm learning all about Aaron's trach changes and suctioning. It's still a little nerve-wracking but everything's fine. I'll have it under my belt in no time."

"Stop it, Linda!" Anne's voice almost shouted. "Your life's not normal. There's nothing very normal about it at all. Stop trying to pretend everything is fine. You need help!"

"Yes, I do!" I shouted back. "But where do I get it? What do I need? Heavens! No one will help, so I have to do it all. We make too much money."

"I want you to come into the Family Support Program, Linda," Anne said. "I want you to start asking for help."

But I argued that other families needed it more than we did. Anne wouldn't take no for an answer, so I finally agreed to begin letting others help our family, and I agreed not to say, "That's okay, I'll do it," until I really thought it over.

This program was our family's life saver. We hadn't seen how consumed by daily living we had become. We had been pushed around by the service delivery system. Finally, someone was saying, "What do you need to help. Daily life for your family is full of stress. Let us help you deal with it. You know best what you need."

Our first big request was competent, caring child care so we could be at ease and go out once in a while. It felt so good to begin living our lives again and enjoy each other. We looked back and saw how stressed we had been before Family Support. It was frightening, but we were very grateful to be moving forward again.

After Aaron got his trach our school district was fearful to leave him in class without my being close so, even though he attended school only occasionally, I took him to school and stayed there, too. I **still** felt that educationally, the special educators knew what Aaron needed better than I. Almost every other area of our lives I was saying, "I knew best," but not in education. And then I attended a TASH (the Association for the Severely Handicapped) conference in Boston in December of 1984 to talk about WISCONSIN'S FAMILY SUPPORT and I happened to walk in on a room packed with people listening to a woman named Marsha Forest.

The workshop being held was one on integrated education. I had never heard of such a thing and Marsha quickly dispelled the notion that it was the same as "mainstreaming," a word I had heard. I sat listening, not having any notion that Aaron wasn't getting the proper education. But, suddenly, I realized that it definitely **was** a segregated education, disguised, but certainly segregated in a self-contained early childhood room.

As I listened I became more intrigued and more upset that Aaron was being segregated and that I hadn't noticed! I watched slides that Marsha showed of a young woman in a special ed classroom who was hanging down off a chair and whose eyes were dull, mouth slack and who slumped around everywhere. "She wasn't the same as Aaron," my mind tried to rationalize. "She can walk and talk for starters." Her parents were upset with her education. She had no friends. She spent the whole weekend at home alone. Her skills at socialization were nil. Her parents asked for some changes to help at school, but they were denied. So, they asked a private school if she could come there. The private school said yes. and she began at a new, Catholic school as a young woman who needed a little extra help, not as a disabled or handicapped young woman.

When I saw the slides of her at her new school, I almost fell off the chair. One had to stare **hard** to see which person in the picture was her! By now I found myself very upset with segregation but I feebly raised my hand to ask one more question, "What about kids with high medical needs? Certainly they can't be integrated, can they?"

Marsha's quick reply was, "What about them? Medical needs are a part of them. That shouldn't prevent integration."

That was it. I knew she was right. I knew Aaron had been denied being around typical children. I knew he just had to have a try at regular education with typical children. And, most of all, I knew that before this day I had been placing limits on how far he could go. My vision for integration was planted and it began to grow right then.

It's one thing to be suddenly struck with a vision that is burned indelibly into your brain–that you don't want your son to spend school in Special Education, but supported in Regular Education. It's another thing to realize what a monumental job it will be to accomplish that vision.

But, I was determined to try. The more I thought about it, the stronger my desire became. And suddenly I realized I had no idea what an IEP, an M-team or any of the other jargon from Early Childhood Programs meant. I felt I had been asleep for almost 4 years! At this time Aaron was with some good teachers with whom I had a good working relationship so I began dropping bits and pieces of information on them regarding my new thoughts. They would look askance at times but supported me pretty well. This gave me confidence that our district would welcome this idea with open arms–Aaron would be in a regular kindergarten because it was the right place for **all** 5-year olds

Did I ever have a rude awakening when I broached the subject with administrators! Still, not wanting to appear unreasonable, I decided to allow what **they** felt best figuring that Aaron would prove he belonged in kindergarten and we would get there anyway.

Without going into lot of details, it was a disaster when Aaron went to a new school at age five to be with all new teachers. He was held in Early Childhood again so "information could be gathered." We were so distressed by Aaron's depressed state by Thanksgiving that we withdrew him from school and really caused a **big** furor. Suddenly the reasonable Browns became totally unrealistic and unreasonable. Even though we argued that this placement wasn't in Aaron's best interest, our rash move of withdrawing him caused hard feelings and no one wanted to deal with us at all. It was a time I soul-searched. "What did I think I was doing?" or had I had been totally crazy, but I kept coming up with, "No." I also studied the law, read articles and was determined I'd be an equal partner in the process to get Aaron an appropriate placement–a kindergarten class. I'd be forceful even if it made enemies. Why not? I had already made plenty by now.

So, we started the process again. In a nutshell the result of a new M-team and IEP was not full-time in a regular kindergarten. Placement was to be part-time EMR (without an MR label and part-time kindergarten. No one would budge. It was August of 1987 and we knew Aaron was going to have to be in a private kindergarten or receive home instruction. We just couldn't accept the placement offered. There was only one tiny ray of hope and I decided to go for it.

During the year we had removed Aaron from school, a friend of mine had told me about sharing my desire for kindergarten for Aaron with a kindergarten teacher in our neighborhood school. The teacher's response had been, "Well, I think both Aaron and his parents should at least have a chance before people say no." When I heard this, something told me to tuck it away in a spot in my mind that I could get to easily. So, I called my friend now to find out if the teacher had really meant it. The teacher just happened to be visiting, so I asked her directly. She said she would be willing to try having Aaron in class, but I'd have to talk to the principal.

My neighbors had told me how open and caring the new principal was. Some of my neighbors also suggested I talk to him about Aaron's going to school in our neighborhood school. A few were ready to sign a petition stating their children should have an opportunity to attend school with Aaron because he lived in our neighborhood. So, since there was no other option except a private placement, I went down to our school, about four blocks away, and walked in to see Dr. Kailin on a warm August day, one-and -a-half weeks before school was to start. With me I had the proposed schedule for Aaron's day from the placement offered as a result of our recent IEP.

I decided that directness was best, so I introduced myself to Dr. Kailin and told him I would like to discuss my son's coming to our neighborhood school. I told him I knew that a kindergarten teacher would be willing to take Aaron in her class and that some of my neighbors really supported his coming there. But, besides all that, I told him that Aaron was a little boy first and that I felt that the offer from Special Education divided him up into too many pieces.

"I'm not saying that he doesn't need help to get places or do things," I told him, "but he's a little boy first and, therefore, a kindergartener first."

Dr. Kailin looked at Aaron's proposed schedule and said, "But this school isn't accessible for Aaron's wheelchair."

"I know," I said. "I've thought about that and, if there's no law against it, I'll carry him in, put him in his wheelchair, and carry him to all his specials. In fact, I'd be his aide for free, Dr. Kailin. I would do whatever anyone needed to help him participate."

Dr. Kailin looked at me long and hard. I didn't blink. "Why should you do that?" he finally asked.

"Because I know an aide would cost money," I said, "and I don't want that to be the reason he can't be in regular kindergarten. It's that important to me, and him, too."

Dr. Kailin said he'd call and talk with appropriate administrators downtown and get back to me. I told him to feel free to stop by and meet Aaron any time. And, he did come two days later to see who was at the center of all this hub-bub. In fact, he asked to hold Aaron and had a heart-to-heart chat with him about how great he was.

The result: somehow, Dr. Kailin and another supportive administrator got other people at our central office to agree to allow Aaron to attend our neighborhood school. **And,** they agreed to provide an aide for him. Dr. Kailin and I interviewed the applicants!

Aaron started in a regular kindergarten on the first day with everyone else. Even though I was told that this was to be a one-year placement only, I was already thinking about how to get Aaron into first grade.

The stipulations were that we had to 1) give up all supports, and 2) provide transportation. Later, when the kindergarten teacher wanted additional help, we started the M-team process all over again to get the necessary supports.

And, now, Aaron is in first grade.

It seems so right having Aaron at school down the street within walking distance. It seems so right seeing kids he goes to school with in the neighborhood and having them wave. It seems so natural seeing the kids at Emerson crowding around him at recess or lunch, saying "Hi" or pushing Aaron's wheelchair. They're great helpers. It seems so right being a volunteer tutor at Aaron's school, being an active participant in his schooling, finally having a voice and pushing for what I think is best and winning people over, little by little. Because, it's an issue of quality education for all children, really.

Why do I want Aaron to be in regular education? Because he'll know how to be in the world with people, not apart from it. Aaron will not walk or talk because he's around typical kids but he's learning to take risks and try some physical tasks he's never done before. Perhaps he'd have gotten there anyway, but I don't think it would have been at the rate he's done so. So often I find in special ed you have to prove you know A before going to B. To me the most important thing Aaron can learn is to be a participating and valued member of society. If ABC's and adding can be achieved too, it's icing on the cake. To see the delight he gets out of various activities he has never done before is truly inspiring. The difficult task is measuring what he's getting and it may be years before that can be done. We have to take some leaps of faith in many areas.

Another challenge is how to provide supports so as not to overwhelm the regular ed teacher. **Everyone** always wants to have a meeting and she just can't. This is a learning process but I can see supports needing to be streamlined so that the teacher and Aaron won't feel bombarded.

I'm not suggesting that special education is bad for kids–on the contrary, with creative approaches and appropriate intervention children with challenging needs can often go beyond predictions about what is expected. Supports are essential but **where** these supports are provided is also paramount. Natural settings provide situations that cannot be contrived and skills acquired there make more sense in the context of life. How to create a model is a puzzlement for in truly recognizing each child as **individual** a model to be duplicated is made more difficult. Still, all I can say is go watch an integrated situation. See what's happening. Then commit to it.

This year has been more up and down than kindergarten. Trying to provide supports in a supportive, non-intrusive way is a challenge. Many, many times it has been disruptive to the regular classroom and the "experts" had driven a wedge between Aaron and the regular ed teacher because they, supposedly, knew more about special kids.

One day the teacher's son was in the classroom for the afternoon and got to observe what was happening with Aaron regarding "the regular curriculum." There were no "experts" there that afternoon. Aaron's aide was on a break and Aaron was allowed to be in a regular math group. After school, the teacher's son exclaimed "Oh, Mom, Aaron really liked math today."

"He did?" she questioned.

"Oh yes," he promptly replied. "Whenever you wrote on the board he got really excited. I know he's getting a lot in your class." As she related this story to me, she said that no one had ever told her anything like that. Since then, they have had a much richer and reciprocal relationship. The process involved in integration is full of such examples.

If I had to go back to starting Aaron's early programming now, knowing what I know, I would definitely do many things differently. But, I'm so grateful to have seen that vision which led me to where I am and led me to fight for what Aaron has today. There are new challenges every day to try to achieve an integrated quality education. But I believe the rewards will be worth the risks and bruises we get to help Aaron and other challenged children become participating citizens of our world.

FOSTERING FRIENDSHIPS

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I thought what I'd do today is to look at friendship. What is it? What kind of practices have we developed in special education to foster friendship and what kind of practices are getting in the way of friendship. I want to talk a lot about parents and families and what they want out of us. And I want to talk about the future. Most of us deal with children who are birth to five years of age and we **transition** them. This is a new word. We have whole processes for transition now. We talk about it as if it really exists, but in reality the child is exactly the same tomorrow as he was today. We forget, by the way, that parents never transition. Parents stay with the kids all the way through. And so I want to talk about that future life, that future quality that exists beyond early childhood special education.

I think it's real appropriate for us as interventionists to look at friendship. I've been in the field of early childhood special education now for nineteen years. Since 1975 I've been looking at IEP's around the country, for little kids, and in all those years all over the country I've seen one IEP that said anything about friendship. Dr. Phil Callisan is the director of special ed for Los Angeles Unified School District. He said to me, "Since 1975, I've looked at 1500 IEP's in a year on all aged kids, and I've never seen a goal about friendship."

So I find myself talking about a topic that makes interventionists uncomfortable. They say, "How can we control friendship? Is that our responsibility? What can we do in the area of friendship? Is that not outside the domain of school?" Yet, all of our research on friendship shows that schools and programs the children are in on a daily basis are the major influences on friendship.

I thought another reason that would be real important to look at friends is that we have P.L. 99-457. We have new legislation; we have a new opportunity with young children. We have a chance to build programs, modify the programs we already have, to really examine what our state-of-the-art practice is. For many of us in this field, we've been given a second shot at building the future. When we first got started we didn't have mandates. We didn't have funding. We built our programs through private means or in ways through school districts that every year we'd worry about whether or not the money was going to be there. And so for all of us that have been doing this for a long time, we have a second shot. We have a chance at looking at building the best services possible.

And of course for all the new people that are now coming in because we're moving into the public education environment, this is the chance for you all to really critically analyze what should be happening. What should programs look like.

Phil Strain talked very clearly this morning about what our research says about integration, what we've learned in the last 15-20 years. Yet it's very clear that what we've learned through research has not become common practice. In fact, a recent report from the U. S. Office of Education points out that children are likely to be more segregated during their preschool years than they will ever be again. Some reports right now say that anywhere between 75 and 90 percent of children receiving services are receiving them in segregated settings. So we have research, and we have practice. And now you know why I see a chance to take a new look to the future, because we can no longer continue to justify our programs by saying that was the best we could do under the circumstances. The circumstances have changed and we have a new opportunity. And I hope it's an opportunity that we will take very seriously. It's going to be very difficult.

Over the years I have been involved in building two different service systems for kids with disabilities, one through a university, which was a reverse mainstreaming model, another through a public school system. And in building those, many people invested enormous amounts of time, energy and resources. Now we're seeing that what we built is not good enough anymore. I think we need to be very careful not to imply that the people that built those services did a bad job, or that what they did was inappropriate. When they built those services, particularly in the mid-seventies and into early eighties, the best we could do was to get a hold of the kids. We didn't have the mandates and the LRE pleas that would allow us to look at serving them in exemplary, integrated ways.

It's interesting though that if you look back into the early seventies, when the first set of early childhood special education projects started around the country, there were two cornerstones for most of those models. One of them was active family involvement and the second was integration. From the beginning in early intervention we have known some of the pieces of quality service, and our early demonstration projects, our early research said integrate and actively involve families. Then we moved out of those model projects into reality and how many of you know in your own states that the reality was that you started with lots of family involvement, you started with home visits, you started with....and then more kids got referred and more classrooms were built, and less time was spent with families. So much so that in a survey in the state of Minnesota it was found that of children in birth to six programs that had a center-based component, less than one-third of the parents had even monthly contact with professionals.

The reality around the country now is that preschool special education means segregation and parents stay home. How many of you know that that is a piece of what has happened to us from where we started? I think it happened because we didn't have the administrators' support, we didn't have the mandates, we didn't have the opportunity, much as I hate to make lawyers rich, to go into court on the LRE for preschool age children. It wasn't required to be serving these kids, so there was a sense that we should just do something that was acceptable.

Here we are, we're almost two decades into education for our handicapped kids, we have almost twenty years of experience as a public educational system working with our communities serving kids with disabilities.

When we look at those twenty years, it's interesting that there are some pretty strong findings that come out of all different areas of research, whether it's research on kids with learning disabilities, severe handicaps, high school, early childhood special education. The number one finding is successful programs actively involve parents as decision-makers. And that is the major predictor of programs that will be considered successful in communities. The second is, and this cuts across all the levels, whether or not a child has had an integrated school experience is a stronger predictor of success in adulthood, vocationally and on the job, than any other variable. Integration is a stronger predictor than severity of handicap, type of handicap, number of years in the educational program, number of dollars that were spent. Integration is the strongest predictor. Integration was a stronger predictor that whether or not community-based instruction had been done. Community-based instruction was the second strongest in predicting success. So we have twenty years of research and practice that you have to involve families, and that success is correlated with integration.

What kind of success is it that I'm talking about? Am I talking about grades, am I talking about scores on developmental measures. No, what I'm talking about when I talk about success is what we generally call quality of life. That is, after school hours, on the weekends or on Christmas vacations, or the summer, and after school years, beyond age 21, 22, 25, depending on what state you're in, where do people with disabilities end up? Where do they spend their lives? What are they able to do? How much are they integrated into the community? We have some successes around the country, but I'd like to share with you three recent failures that I experienced, that have really had an impact on what I see is our purpose in special education. The first is a recent experience with a grandmom, who has a little boy by the name of Joseph that she's raising. Joseph has Down Syndrome. He's been in an early intervention program where his brothers and sisters come with him, the brothers and sisters of other children with disabilities are included with him. Moms, grandparents, dads, uncles, etc., are included too. So, although they have a center, everybody sort of comes in and then once a week somebody goes and does a home visit. They have a structured curriculum with a scope and sequence. Parents actually do the evaluation of the project and conduct the questionnaires and summarize the results and present them to the administrators, so that the parents know what they think about it before the administrators know what they think about it. And Joseph is "transitioning" out of there at age three, because this program ends at three (how many of you have had that problem in your state?) and grandmom really wanted him to be in an integrated preschool setting. She thought that he had done real well with the other children. She went to a Head Start program with him and his early childhood special education teacher and as they walked in the director of the center came over and said "We don't take that kind" to grandmother, to Joseph, and to the teacher—1988.

Number two example of what concerns me was a letter recently in Dear Abby. How many of you read Dear Abby? (Applause if you're Abby readers. I won't tell you what else I read for factual information.) There was a letter in Dear Abby about going out to a restaurant to eat and one of those people was there in a wheelchair drooling over their food, and why didn't those people recognize that other folks didn't want to be subjected to that at their meal time. After all, they could eat at home. Dear Abby did a do a wonderful job, by the way, she really does, by defending the rights of all people to eat out. But that was 1988 too.

The third example occurred in 1987, and I really won't identify the community where it occurred. A small community outside of Madison was about to have a group home located there. It was going to be a group home for women who were labeled chronically mentally ill, mentally retarded. They had been institutionalized for a long time, they were coming out. How many of you have had this in your community? And in this group home there was going to be four of them. Because they were four unrelated people, you had to get a zoning variance. How many of you live in residential areas where that's required? How many of you don't know? I was appalled to find out that that's true in the neighborhood where I live. I don't know that I ever would have bought there if someone would have said to me, "If you're going to live there, you have to get a zoning permit." The group home developer really didn't think there would be a problem. They had good staffing and the women had no history of violence. So they go before the zoning board, and I happened to be there that evening with a parent to talk about something else. I'm sitting there and the first person that gets up to talk about this group home is the Catholic priest from the parish right across the street from the group home. So I thought: well this is great, and then the priest proceeds to point out to the zoning board that he really understands that these women need somewhere to live and that it would probably be better for them to live in the community, but he really thinks that the zoning board could probably help find a better place than that house, because, after all, he has lots of parishioners that come into his church service on Sunday and those women might be wandering around the parking lot while his parishioners were there. And I thought to myself, although I didn't jump up and say it, "I don't understand this. From what I knew, God would invite them in! Never mind wandering around in the parking lot!" But he wasn't going to invite them in.

So where are we in 'quality of life? Where we are is that we have a lot of individuals with disability that we're diverting an enormous amount of public educational money to, with very little chance of them being successful in adulthood. Because the adult community is very unready to take on these people. And so when we look at that and look around and we talk to families of individuals with disabilities who are adults, one of the things that seems to be missing is that in the educational process our IEPs tend to focus on very specific skills. Those skills do not necessarily lead to, when you put them all together, successful community functioning. Because very often the skills we teach are the ones that we can teach in isolation, that we can sit the child down and accomplish. And yet, in order to succeed in life in the way I'm talking about, the skills we teach have to somehow impact on a community's respect and the dignity that is given to individuals with disabilities. And it doesn't just rest on what they can learn in our programs. We can't teach communities to respect and value individuals with disabilities by keeping people with disabilities in our separate programs.

When I reached that great revelation a number of years ago, it was startling that I also found that its something that parents have been trying to tell us for years and that they figured out way before 94-142, and as a continuing part of 94-142, they keep saying to us, "What about the future?" " What about tomorrow?" " What about the neighborhood?" And, in fact, Chris Salisbury and I did a little bit of research a couple of years ago where we asked families of all different kinds of kids with disabilities to write down what are the five things you would like for your child in adulthood, when they reach 21 and 22? What are the five most important things for you? We also asked companion professional staff to write down those five things. The first very interesting thing was that there was only 23% overlap between what the parents said and the professionals said.

The other thing that was really fascinating was that within the parents there was enormous consensus in what they said and within the professionals there wasn't...How many of you have been to a multidisciplinary team meeting recently? You have the occupational therapist, the teacher, the speech clinician, etc., all with their own opinions. There was very little consensus among professionals about what the focus should be. We started wondering about what are the common themes that parents were telling us. What were they saying to us they really wanted for their kids? And could we take that to heart? Could we take those goals and look at building special education services, early childhood onward, that would reach those goals?

The first goal that was listed by over something like 85% of the families was "In adulthood I want my child to be happy and have friends." Just as Phil Strain was saying this morning with the early childhood kids, friendship—feeling good about yourself, having people who like you—was a recurring theme in all the families with whom we talked. They all talked about that piece. They wanted their child to know that other kids liked them. They wanted their child to know that somebody interacted with them who wasn't paid to and didn't have to. They wanted a sense that their child was a capable interactor, could be a friend to somebody else.

The second thing the parents said to us, and again they said in a lot of different ways, was that "I want my child to live in the community." Bob Perske says this by saying "I want him to be a neighbor." I want my child to grow up and be somebody's neighbor and have them know that he or she is their neighbor, and want them to be their neighbor and know their name; and know that they can go to the local store and people will know who they are; and that they can ride the busses and they can go to restaurants and they can go to bowling alleys and parks—that they are a part of our community. That they have that community respect that says they belong in this neighborhood as much as anybody else.

The third thing that parents said to us they said in a lot of different ways, because we were talking about parents with very very severely involved kids, as well as parents of learning disabled kids. They said to us, "I want you to figure out a way that my child can give back to society as well as my child can take from society. I want you to figure out a way that my child can make a contribution. I know right now that he can't work full time for minimum wage, he's going to need a job coach, he's going to need a supported employer and the co-workers are going to have to help, but there must be some way that my child could do that, and can have that sense of mastery, and that sense that comes with contributing and not just taking."

How many of you in this room have kids without disabilities? How many of you would set these three goals as the goals for your kids? I want them to have friends, I want them to have respect, I want them to contribute. And I want them to be on the go out there, I want them to make a difference.

Parents knew what kind of future they wanted. It wasn't the future that we looked at as professionals. And so we decided that maybe we should look at how close we were to getting that future. And so I went out and I looked, particularly at the last one, making a contribution to society. And interestingly enough we found out that this really wasn't all that difficult to do (You sort of feel you take the most improbable first). Well there are folks all over this country who have individuals with very severe disabilities out doing community work. And, in fact, school districts and programs they have chosen have almost 100% graduation rate to community work rather than sheltered employment.

It looks pretty clear if you look at Virginia Commonwealth, San Francisco, Madison and De Kalb, Illinois that people do not need to go in to sheltered workshops. And in fact we can build employment in the community that is as successful for even the most difficult worker. One of the more interesting findings to me has to do with "Do you want to?". For example, Madison, Wisconsin decided that all of the kids graduating from their program for moderately and severely handicapped students would go into community work. They made that decision, implemented the curriculum, got the job coaches. Last year 95% of the kids graduated and went into community work. At the same period of time in the state of Montana they did a study of where do students with learning disabilities go after high school graduation. The end result: 95% were unemployed. Now that is an example of what do you choose to do, what is your goal, what do you want to get out of this. Have you looked to the future, are you letting a future drive part of what you're doing now.

So I think the message I give you is that we can make a difference in terms of contributions to society, we can get folks out in jobs. The other thing that's very interesting about that is that whether a person stays in a job does not have to do with their skills related to the job, but has to do with social skills. And again, it's very clear that the ability to interact with the non-handicapped workers, bosses, whoever, on the job site is more important than the exact job task. If a person can't do a job fast, somebody will figure out how to adapt it or teach it to them. If they are having trouble interacting it is likely to get them moved to another job. So we come back to that social piece.

What about the other two goals? How about the goal of happiness and friendship, and how about the goal of community respect and dignity? Well, I think one of the things that's really clear, as I started saying a few minutes ago, is that we can't teach those directly in our special education programs. To the extent that we are focused on mainstreaming our segregated special education programs we can't work on two of the things that parents think are very important. The reason for that is that success in the friendship and community dignity areas depends on children without disabilities seeing children with disabilities as possible friends, as capable contributors, as people who make a difference. Now my earlier examples of Dear Abby and a priest and a preschool program would say that there are a lot of folks out there that don't see individuals with disabilities as capable, as deserving community respect, as having a place. And in fact it looks like there are a lot of folks out there that still believe that it's not o.k. to have a disability. And, in fact, if you have a disability, you need to be separate. How many of you know that your parents believe that? How many of you know people in your your own school districts that believe that? We have programs all over the country, where if you have a disability, you automatically are separated. As soon as we do that we can't be successful in reaching those life goals. And so what we have to do is figure out a way to teach typical kids that children with disabilities are potential friends.

The literature on friendship formation is really easy. It says one thing: "In order for friendship to occur, there must be proximity and frequent opportunity for interaction." In fact the literature on young kids friendship is pretty clear, as Phil Strain was saying, that needs to be almost daily, and it needs to encompass the whole time that children are in learning settings. And so there is some research that shows if there is a whole day program and some kids are only there a half day, and the rest of the kids get a whole day, the whole day kids make friends with each other and the half day kids make friends with each other. And maybe this makes sense, and maybe you've seen this with your own kids. I mean, that's why I like research, you know, it's really simple. It gives you these nice conclusions. And so it's real clear that friendship is based on proximity, opportunity and inclusion as an equal. Not somebody that gets put in for play time and then leaves for the whole rest of the day.

Now the second thing that seems to govern kids' friendships is that they have to believe they have something in common. This can be with three and four year-olds, you say "She's my friend" ... well why is she your friend?..."She sits next to me". That's a very standard reason for labeling someone. Isn't that wonderful when you talk about kids with disabilities? And in fact the literature is really clear that the first part of friendship is inclusion, and that that is absolutely essential, necessary, but not sufficient. The second thing is shared activity and a shared sense that you have something to contribute. Now the other thing that's really nice about little kids is that this is really easy to do because shared interest between children is totally governed by adults and parents. How many of you have been in day care centers recently and preschools and know that dinosaurs are in? How many of you believe that the children are into dinosaurs? How many of you know that the adults are into dinosaurs? I have a little two-year-old friend named Nathan whose first word was dinosaur. His whole room is dinosaurs, the shower curtain is dinosaurs, everything. He has suspenders and he'd walk up to you at 18 months and he'd point and say dinosaur! Everywhere this kid went that I went out in the community with him and we encountered other parents of preschool kids, they immediately could talk about dinosaurs. Nathan had a common interest with other children because his mom and dad love dinosaurs and their mom and dad love dinosaurs. Another example of that is a little guy I know out in Colorado whose 7 now, he lives in Denver, and he's a Denver Bronco's avid nut. His mother is a Denver Broncos' fan, and his whole room is decorated in Denver Broncos, and he has Denver Bronco shirts... And when he got integrated into a regular first grade—he's a severely handicapped child, wheel chair bound, hearing impaired, he's got a tracheotomy—the first day he wore his Denver Bronco's shirts, he had three new friends in the classroom, who liked the Denver Broncos. And they would start coming over and so the teacher wrote a note so his mom would send Denver Bronco stuff in. Pretty soon Winslow was getting invited to birthday parties. Friendship with little kids is such an easy piece. It is one that we have so much control over, that if we take some time with typical kids we can give them the skills to foster those friendships. We can also give kids with disabilities skills to foster friendships. We can build that into their IEPs. Mostly we talk about the benefit for kids with disabilities of friendship and we talk about all the things that they're going to get out of this and that it's so important for them to be in these settings and to have these friends. I've actually become convinced that it's probably more important to the typical kids in some ways, than it is for the kids with disabilities. And I really have become more aware of that this last year, as I traveled around the country talking to kids who are between about 7 and 12, who have brothers and sisters with disabilities that get sent to different schools than them, and get bussed out of the neighborhood. How many of you have areas like that? If you have a disability, you don't get to go to school where your brothers and sisters are. And I started asking these kids, "Now, why does that happen?" And it was really scary, because they started telling me why it happens, and they told me, "Well, it's because he doesn't belong with us." "She can't learn with us." "It would be too hard for us to learn if she was there." "The teachers wouldn't know what to do if Ryan was in our classroom." Aren't those all reasons that we don't integrate as professionals? Are those kids all making up something that we don't also know. So what's happening is all over this country we've got typical kids that are learning it's not o.k. to be different. It's not o.k. to have a handicap.

It's not o.k. to need special help. It's not o.k. to be not exactly like everybody else. And when I think about that kind of message for today's kids with the stresses that we have on kids, and the issues of drugs later on, and the fact that kids have to really believe in themselves to resist that, we're missing an enormous opportunity to teach kids about individual difference. And we are creating settings that are artificially the same, and in doing that we're giving kids the message "You'd better be like everybody else, because it's only if you're like everybody else that you get to stay in this school." How many of you are in districts where if you need special help with reading, you may get sent out of your home elementary school? You may get sent to another elementary school on the other side of town. There are kids all over this country that are having problems just with reading, that are being send somewhere else. And then of course there are kids with more moderate and severe handicaps who right away get sent somewhere else. And so I think that we're really creating a myth with typical kids, and we're teaching them some things that those of us who are in early childhood special education really regret in the long run. That is, we're teaching them as the future parents, cousins, in-laws and brothers and sisters of children with disabilities, because some of those typical kids out there are going to have someone with a disability come into their family, we're teaching them that that's not o.k. And the difficulties that we report in our literature on parental adjustment and adaptation, all the stress we may be actually perpetuating by our segregating programs. Because the kids are worrying that if your child has a disability, they're going to have to go somewhere else, it's not o.k., they can't compete, they can't be part of the group. And so I think we are really hurting our own causes as well as hurting the kids without disability, as well as hurting the kids with disability. It's really clear that if we're going to get there in adulthood, we're going to have these people who go out and live in communities and have community respect, we need to teach typical kids that it really is o.k. to have a handicap, that it really is o.k. to be different, that you can actually learn from people that have handicaps. And that just because you have a handicap you're not always the tutee and somebody else the tutor. Just because you're typical doesn't make you always the model.

There are, in fact, individuals with handicaps that can do some things better than you can. They may be able to run faster or read better or do their math better than you can. And I think that one of the biggest mistakes that we've made in our special education efforts so far is that we have done what we've call mainstream kids and you notice that almost everybody today isn't talking about "mainstreaming". We talk about integration, we talk about least restrictive. One of the reasons I think we made a mistake is that when we built the mainstreaming model, and I hope it's something we don't do in early childhood special education, we built it on the concept that you got included with typical kids, if you could compete with those typical kids, and you could do exactly what those typical kids were doing. How many of you have kids with disabilities with whom this will never work? They're not going to be able to compete and be in that setting. And so what happened in mainstreaming is we kept trying to find ways that kids with disabilities didn't have disabilities. And kids with handicaps didn't have handicaps. And then what we would do in those settings, is that we would say to the regular educator who had 25 or 30 of them, "Oh, and by the way, Bill will be joining you for math, because he's o.k. in math."

When I talk about this I always see some special educators eyes light up because they were never sure they liked regular education anyway. And so some of the opposition to mainstreaming was from special education teachers. And in fact some of the attitude research that's been done says the worst attitude towards mainstreaming is held by special education teachers, and the best attitude is held by parents of typical kids. They think it's a great idea, parents of kids with disabilities think it's a great idea, teachers of regular kids think it's an o.k. idea, and teachers of special education think it's the worst thing they've ever heard of. And so integration has none of that—it says we have resources, we have kids, we know what's important to them to learn, we really know the importance of social skills, we know the importance of communication and communicative intent. We're not going to leave fine motor, gross motor, cognitive and all those things behind, we're going to work on those skills as well. But we're pitching for the future. We're looking at age 22. We want to make sure that the educational dollars that we invest for 22 years in a child's life pays off. In a community that is responsive and accepting, a community that really makes the difference.

I just recently got introduced to a group of principals and assistant principals for segregated preschool programs as one of those radical integrationists. And given I was a child of the 60's, I kind of like the idea that I was a radical. The problem is that integration is not radical. In fact, integration has been around for 20 years. And then I got kind of worried because I thought I was supporting an establishment cause. It was time to figure out something else to support here! As I get introduced and as I talk to groups like this I've learned to say something really clearly. That is, I do not believe that the solution is to put children in regular education with no help. I fully believe that every single dollar that we invest in special education programs must follow children into regular education, regular day care and regular preschool environments. We're not talking about an alternative to specialized help, we're talking about help that delivered in a different setting, and maybe delivered in some different kinds of ways—maybe kids with each other rather than adults all over the top of them—but we're talking about the same cost. The little bit of cost data that I've seen will say it's really the way we want to go because the integrated settings provide more resources. If you hold on to all your dollars, you know I saw a figure recently that the average early childhood special ed program in this country cost $8100/year by the time you figure transportation. I remember back in the days when it was $450. So we have a lot of money available to use for the integrated setting, and I'm not advocating to integrate to save money. I'm advocating we use all this money and volunteers to make integration work (Grandparents, parent volunteers and high school students can be trained to work with children). We're talking about lots of ways that we can use people, and it's not going to be easier out there in an integrated setting. I think we're going to have to look at a lot of alternatives. There isn't going to be one model that fits every school district or every program. I think within school districts you probably will want to have a range and then that gets to the issue of a continuum. Continuum is really difficult for me, because I think by building that in to 94-142, as much as I really love that law, we created the notion that segregation was appropriate for some children. And by putting it on the continuum, segregated classroom, segregated schools, we've said to people some of the children that you look at belong in this category. And so then people started trying to find those kids. And once they found those kids in their view, every other child like that became one of those kids. And I would like to see us, at least in early childhood special education, start with the notion that least restrictive environment means that you are placed in the setting which you would go to if you did not have a disability and if that's center-based, then you will be placed in a setting that other children in your neighborhood would go to who needed a center based setting. And only after we've attempted to adapt that environment, train personnel, hire additional staff and change materials, will you be removed to a segregated setting. Now I'd like to say that kids don't move at all, I mean the teacher has to figure it out from that setting.

I have enough confidence if we do it that way we'll figure it out, that I sort of allow that probability. Have you gone through that? And you've taken ninety days, and you've worked with the parents, and you've trained staff and you can't do it, then we probably should send an outside consultant to come out and help you... The other thing is I know not all teachers want kids with disabilities. You know that we don't need all teachers to work with us.

It's real clear now that the regular education staff that is buying into integrated models is having a much better time. They're having a lot of fun, and they will tell you how much more motivated they are. So we don't need to make every teacher do that. But we need enough range and models to fit the situation, and we have enough people out there that are willing to integrate, then it's really not an issue. And all over the country I have people saying "Lisbeth, the regular educators aren't going to allow me to do it." Day care center teachers, preschool teachers, family day homes are saying, give us some assistance, give us some support. Very often when they won't buy in it's because someone told them, they didn't know how, it would be too difficult, and no one would give them any extra help.

And so for me integration is, you put them all in, you take your resources, and you figure out how to make it work. And we know what some of those pieces of quality are now. We know how to make it work. That's not experimental at this point in time, that's not the experimental piece. We know what makes the difference in terms of structure, instruction and intensity. The model that I talk about is one where you adapt environments, you change environments rather than changing children's placements. It's one that is built on the notion that from the earliest time possible kids with disabilities and kids without disabilities should be together as frequently as we can possibly figure out how to do it as a community. Because young kids are forming their attitudes and that is when they learn about disabilities. And that's when we have the best opportunity to create similarities between kids and tap similarities that are already there to really pay off friendships that form. That's when it's easiest for us. The difficult behaviors are often less. The discrepancy is less. The proclivity to want to be together and interact with each other is more. The curiosity about kids with disabilities is higher at 3, 4 and 5 some researchers say. That curiosity, if it's not dealt with, turns into fear and age 7, 8, and 9. We have real opportunities at the young ages.

I think what we have is the opportunity to learn something, that families have had to learn all along, and have tried to talk to us about as professionals. We've always shyed away, we've always been uncomfortable when parents have started talking to us about their feelings and their kids and the value that these kids had in their lives. And I always see early intervention professionals squirm when parents start talking about how important it is and what they've learned, and the brothers and sisters have learned, and it's brought their family closer together. They really had to examine their values. They've had to figure out what"s important. They have had to make decisions about what priorities for this family will be. As families talked to us about that I think where our discomfort comes because we're trained to see the disability. We're trained to put the disability first. We're trained to make it the most important thing about this child. And we're going to do it in a negative way, in a way that says that this kid doesn't measure up.

Parents end up looking at their kids really different than that. They see the whole child. They see temperament rather than a wheel chair. They see humor rather than the problem behavior. They see interaction between two brothers rather than the lack of writing and math skill development.

They see this kid as fitting in and being a contributing member of their family. I think that's why they're so convinced their children can be a contributing member of our society, because if they can do it as part of their family, then truly they can do it out there. And in a sense I think that what the families have learned is like probably 20 years ahead of where we were.

In the seventies we started integrating kids, and if you read the literature (and it really appalls me when I read it now) we talked about tolerance, we talked about the purpose of doing this was that people could be taught to **tolerate** individual differences. And then in the late 70's, and I wrote some of this stuff, you read the literature and we start talking about **acceptance,** and the idea we should accept people for who they are and what they bring. We were all more comfortable with that and we felt a lot better about ourselves. We still have a step to go as professionals. It's a step that families have already made. And that is that the issue is neither to tolerate nor to accept. This issue is to **cherish,** and the issue is to **respect.** And the issue is to recognize that each child is a unique individual that we have the opportunity to learn from, with whom we have the opportunity to be friends. And while we may look and see severe handicaps and we may look at two kids interacting in a classroom and say "You know, Adam is doing all the giving here, and Aaron is doing all the getting here, is that really friendship?" A measure of friendship is not what you and I think when the two of them describe themselves as friends. And I think probably the most important thing to remember is that for many of us, if we look back or we take a minute to reflect, situations we thought we were giving so much, are the very situations where we ended up getting the most, and the situations in the long run we realize we were the learners. We were the person that benefitted, as much as that friend with whom we were interacting.

And so I hope that now with our new legislation we can join the parents in their dream. A dream that isn't just vocational success, but a dream that is community respect; a dream of friendship; a dream that in a sense would have us 20 years down the line look out there and be able to say "Individuals with disabilities are in every part of my life. They're where I work, they're where I live, and they're where I play. Thanks very much.

2 MODULE

WHO ARE THE CHILDREN?

TRAINER'S NOTES

2 MODULE

WHO ARE THE CHILDREN?

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2 MODULE

WHO ARE THE CHILDREN?

I. MODULE OVERVIEW

LENGTH OF TRAINING

This module is designed to be completed in two 3 1/2 hour sessions, for a total of seven hours. It is suggested that the trainer complete section III in the first session, and the remaining sections in the second session. This time allotment includes approximately 30 minutes for breaks. It is recommended that the fourth session, Module 3, be conducted 2-7 days following the completion of Module 2. This time frame will allow participants an opportunity to complete the Field Exercises while keeping the information current.

A. Purpose and Goals

Purpose: To provide information on the abilities and needs of young children with and without disabilities

Goal 1: To provide information on the individual needs and abilities of all children individually and in groups

Goal 2: To provide information on the impact of disability on early childhood development

Goal 3: To provide information on teaching strategies for young children with and without disabilities

B. Trainer and Participant Expectations

The trainer should present the following expectations to participants. The expectations should be used as a guide by the trainer to insure that the important material is covered during the training session.

1. The trainer will provide participants with the information to be able to describe one area of development of young children;

2. The trainer will provide participants with the information to be able to describe some of the issues involved in labeling children according to disabilities;

3. The trainer will provide participants with the information to be able to describe the impact of a particular disability on early childhood development;

4. The trainer will provide participants with the information to be able to explore feelings, values and attitudes about disabilities in young children with disabilities.

C. Additional Resources for the Trainer

Bredekamp, S. (Ed.). (1987). *Developmentally appropriate practice in early childhood programs serving children birth through age 8.* Washington, DC: NAEYC.

McCormick, L. (1990). Child characteristics that affect learning. In L. McCormick and R. Scheifelbusch (Eds.). *Early language intervention: An introduction.* (pp. 143-179). Columbus, OH: Merrill Publishing Co.

Safford, P. (1989). *Integrated teaching in early childhood: Starting in the mainstream.* White Plains, NY: Longman, Inc.

Wolery, M., Strain, P., & Bailey, D. (1992). Applying the framework of developmentally appropriate practice to children with special needs. In S. Bredekamp, & T. Rosegrant, (Eds.). *Reaching Potentials.* Washington, DC: National Association for the Education of Young Children.

II. SUMMARY TRAINING OUTLINE

LENGTH OF TRAINING FOR EACH SECTION ▼

The summary training outline is provided to trainers as an organizational tool. It describes the basic outline of the content, appropriate places for training activities, and the presentation of audiovisual materials. A space has also been provided for making notes about materials, equipment and other training needs.

Key:

🏃🏃 = Activity

▭ = Overhead

◔ 15 *minutes*

Opening Discussion ▭ #1- 4

- Introduction
- Review of Module Goals & Expectations & Themes
- Review Field Exercises

Notes:

● 2 *HRS*

How Do Children Learn? ▭ #5- 8

- The Child's Perceptions of the World
- Child Characteristics that Impact Learning
- What Do Children Do?

🏃🏃 #1,2 or #3

🏃🏃 #4 or #5

Notes:

2 HRS

Child Characteristics that Impact Learning #9-13

- Issues Related to the Use of Labels
- The Effects of Child Characteristics on Early Development

#6 or #7

Notes:

#8

2 HRS

Facilitating Learning in Integrated Settings #14

- Developmentally Appropriate Practices
- Enhancing Learning for Children

#9 or #10

Notes:

45 minutes

Closing Discussion #15

- Journal
- Review Expectations & Themes
- Review of Future Sessions
- Review Field Exercises
- Collect completed Workshop Evaluations

#11

Notes:

III. HOW DO CHILDREN LEARN?

#5

KEY IDEA: How a child learns is impacted by many factors. Some of these factors are related to the learning environment, while others are related to individual child characteristics. One way of categorizing the characteristics that can impact learning is: sensory abilities; processing abilities; ability to respond to the environment; and motivation. While all children show variability across these four factors, there is still much consistency in the general progression of child development.

#1,2 OR #3

A. The Child's Perceptions of the World

A child's level of development can have a dramatic impact on his/her perception of people and activities. Teachers should be prepared to model behaviors that promote the respect and celebration of differences in gender, culture, and abilities. With respect to young children with disabilities, adults should be aware of how a child might view a peer with a disability and should assist all children in understanding disabilities and differences.

#6

B. Child Characteristics that Impact Learning

Learning is effected by a variety of factors: the learning environment, the characteristics of the teacher, and the type of learning that is occurring. Other important factors that can impact learning are individual to each child. Important child characteristics that can impact learning are: Sensing; Processing; Responding; and Motivation. All children combine these four characteristics into a learning style that helps them understand and learn from their environment.

1. Sensing

A child's sensory abilities, auditory, visual, gustatory, tactile and olfactory, provide an enormous amount of information about the world. Learning is impacted by the acuity and efficiency of the sensory abilities and the ability to use sensory information to make discriminations.

2. Processing

One child characteristic that can impact on learning is the child's knowledge of and ability to use a variety of learning strategies. Learning strategies are "complex interrelated processing operations which the child applies between sensory experiences and responding". (McCormick & Schiefelbusch, 1990) Learning strategies, such as selective attention, concept formation, and memory strategies, help the young child make sense of his/her environment. Selective attention refers to the ability to attend to or focus on the a particular feature of a stimuli. Concept formation strategies provide a format for distinguishing and categorizing sensory input. The final learning strategy encompasses the ability to store and retrieve conceptual information. Memory strategies include methods to store and retrieve information in both long and short term memories.

3. Responding

Responding refer to those observable behaviors that a child produces in response to a particular situation or sensory experience. As a child's responses become more differentiated, some indication is given of the learning strategies that are being used to learn about the environment. The child's responses may be composed of a variety of different types of behaviors, for example, vocalizations, reaching, showing, imitation, etc.

4. Motivation

The final child characteristics that can impact on learning is motivation, the reason or purpose for an action or response. The child's interest in manipulating activities and people in the environment is a key factor in learning. Motivation is effected by both intrinsic and extrinsic reinforcers.

#7

#4 OR #5

C. What do Children Do?

Child development scales tell adults what children "do". From this information, adults infer what children "know". The consistency of these scales highlights the consistency that exists from child to child as they develop. However, when addressing the issue of what children do and know, care must be taken to consider that considerable variability in the development of young children exists, that all areas of development are highly interrelated and that a child's level of development can have dramatic impacts on his/her interactions with peers.

1. Variability in Development

Every child is varied in their development, and therefore, developmental stages should serve only as a guideline. However, developmental information can be useful in developing activities and programs that are age-appropriate. Care should be taken to insure that developmental charts were normed on children of the same gender and similar culture and socioeconomic situations.

2. Holistic Approach

Emphasis in child development should be on the child as a whole, rather than as separate pieces (e.g., motor, cognition, communication, etc.). Many of the skill areas overlap, especially in young children. Children become effective learners through the integration of many skills. Adults are effective facilitators of learning when activities concurrently stimulate many developmental areas.

3. The Effects of Individual Development on Group Situations

A child's level of development will effect his/her interactions with other peers within a group situation. A group of 2 year olds may in fact be a very diverse developmental group. Teachers will need considerable skills, resources, and planning to keep a very diverse group of children participating in the same activity.

2 MODULE

WHO ARE THE CHILDREN?

IV. CHILD CHARACTERISTICS THAT IMPACT LEARNING

#8

KEY IDEA: It is not necessary and is very impractical for all adults to know everything about every disability. It is more important to have a basic understanding of the potential effects that some child characteristics may have on normal early childhood development. Children with the same disability label do not have the same skills and abilities. In fact, children with the same diagnosis are often more different than they are alike. More importantly, children with disabilities are not very different from children without labeled disabilities. For these reasons, this discussion will focus on ways in which children with disabilities may learn, rather than specific characteristics of the disabilities.

#9-10

#6 OR #7

A. Issues Related to the Use of Labels

1. Why Use Labels?

In some instances, labels can provide assistance to families and service providers. A child's label can provide needed services to both the child and family. The label can also assist the service provider in developing appropriate intervention strategies. However, labels can be harmful to young children in a variety of ways. Examples of the harmful effects of labels include:

☆ Children with the same label are often dramatically different from one another because each disability label is used to describe a range of developmental impact.

☆ People are often tempted to predict the future for young children based on a diagnostic label.

☆ Labels may not be very accurate due to difficulties in testing young children.

☆ All children with a specific disability label do not benefit from the same educational strategies.

☆ A label may reflect only one area of need and therefore, the child may not receive all the services that are needed.

☆ When a particular label is attached to the child, certain limits are created with little expectation of changing outcomes.

☆ Labels direct our attention to the disability of the child, rather than the child's abilities.

☆ Labels can keep children from being included in regular early childhood activities.

☆ Labels tend to follow children for the rest of their lives, even when a disability no longer exists.

#11

2. Respecting Diversity in Others Through Language

Our society is often tempted to describe its members based on certain characteristics such as race, religion, nationality, gender, or other physical attributes. By doing so, society emphasizes characteristics that group persons together with some people and subsequently apart from others. It also allows us to make generalizations about people because individual abilities are ignored. This process shows a lack of respect for the dignity of the individual. Persons with disabilities are often recipients of this type of disrespectfulness. Therefore, it is important to use people-first language. People-first language acknowledges the individual first and the disability second. For example, "Children with Disabilities," should be used rather than "Disabled Children." By using people-first language, we can help protect the dignity of the individual.

#12

B. The Effects of Child Characteristics on Early Development

#8

Children with disabilities are often given a label because they have difficulty in one of the four child characteristics that effect learning (sensing, processing, responding, and motivation). While a disability label may provide some information, more information will be provided by examining the impact the disability has on how a child learns.

It is also important to understand that children with a particular disability label may show an impact in one or more areas of the child learning characteristics. The four areas, although discussed separately, are highly interrelated. An atypical effect in one area may have an impact in one or more of the other areas. The combination of multiple handicaps can effect the development of a young child much more than the effect of each single disability. The range of severity of a particular disability will also differ from child to child.

2 MODULE

WHO ARE THE CHILDREN?

1. Sensing

How a child learns can be effected by the amount and the accuracy of environmental information that is received through the senses (auditory, visual, tactile, gustatory, olfactory and proprioceptive senses). Any impact on how well a child receives information or the accuracy of the information that is received, can cause difficulties in learning. The most common labels of disability associated with difficulty in using senses are vision and hearing impairments.

The learning difficulties associated with hearing impairments have a primary effect on a young child's ability to learn to communicate. However, early communication difficulties can also effect the related areas of social and emotional development. The severity of impact from the hearing loss is effected by: 1) The degree of hearing impairment; 2) The age of onset of the hearing loss; and, 3) The age when the hearing loss was detected and intervention was begun. A child who has a mild hearing loss that was discovered early and who was provided with early intervention services will have a lesser impact on learning than a child with severe hearing loss that was diagnosed later in life and who has received few early intervention services.

A young child's vision can be effected in a variety of different ways, including acuity problems, field losses, and difficulties with muscle imbalance. Children with vision impairments are often limited in the ways they have available to learn about their environment. Because of vision impairments, these children may only see a small portion of the environment or may be limited to exploring the parts of the environment that are within reach. Because of the impairments, they may have difficulty in motor and eye-hand development and in development of spatial awareness. Children with vision impairments may have additional difficulties with language skills. They are often very verbal and imitative of auditory information, but may use words and phrases they do not clearly understand. Children with vision impairments may also miss many of the nonverbal facial and body cues that are available to other children. Vision impairments may range from very mild acuity problems that can be corrected with glasses to children who only respond to the distinctions between light and dark.

Difficulties with sensing may also be associated with children who have physical impairments. Because of difficulties in receiving information tactually and in exploring their environment, children who have physical impairments may have difficulties learning about their environment. Children with physical disabilities may also experience difficulties in the related areas of communication, physical awareness or expression of feelings. Physical impairments can be very mild and very difficult to see, while others may be more severe and more noticeable. Children with physical impairments may have additional impairments (such as mental retardation) but often do not. The effects of health impairments on normal child development depend a great deal upon the type of health impairments. Some health impairments may limit the child's ability to move and an effect in the area of mobility may be noticed. If the health impairment impacts the respiratory system, language development may be effected. Medications that the child is taking may have additional impact on their development.

2. Processing

Children who have difficulty developing good memory skills, basic concepts, and selectively attending to environmental stimuli may have more atypical learning strategies. These children may be given the label of mentally retarded, cognitively impaired or learning disabled. Children who have difficulty with input modes, such as children with vision and hearing impairments, may also have difficulty with selective attention and concept development because of the incomplete information they have received about their environment. Children who are given the label of social/emotional impairments, in particular, children with autism, may often have difficulties with being overly selective in how they attend.

Young children with disabilities may have delays in all areas of development without having been given a diagnosis of cognitive impairments or mental retardation. Because of the age of the child, they are often given the label of "developmental delay". These children usually have delays in all aspects of development. Cognitive impairments may range in severity from very mild to severe with the more severely involved children often having additional disabilities. Severity is often determined by the degree of delay. In school age children, intelligence and adaptive behavior tests are often used to determine severity.

3. Responding

Response capabilities, the observable behaviors that a child produces in response to environmental situations or sensory experiences, can be different. Children who are given the label of speech and language impairments or physical impairments may have difficulties in their response to the environment. Other children who have sensory difficulties and difficulties in using effective learning strategies can also show impacts in this learning characteristic.

Speech and language impairments are one of the most common disabilities in young children. The impairments may effect how children speak (articulation, fluency and voice disorders) and/or what they communicate (language disorders). Language and communication is the primary area of development that is effected. Speech and language impairments may effect how the child expressively communicates and also how the child understands language. A related area that may be effected is the expression of feelings. Children who have difficulty expressing needs, desires and feelings may resort to other behaviors (e.g., hitting or throwing) to meet their needs. Speech and language impairments can range in severity from very mild articulation disorders (Children who say "thoup" for "soup") to those children who have no method to communicate because of physical and/or cognitive difficulties.

4. Motivation

Difficulty in the area of motivation, both extrinsic and intrinsic, may have an effect on how a child learns. Children who are given the label of social/emotional impairments may show atypical motivational responses. In addition, children who have difficulties in the other areas that impact on learning; sensing, processing, and responding may also have difficulty in the area of motivation. These children, because they have learned that their behavior has little impact on the environment, may lose any motivation to learn.

Young children who have social or emotional impairments show unusual behaviors for long periods of time. The unusual behaviors may be described as: withdrawing, anxious, and/or aggressive. The primary areas of development effected include: expression of feeling and interest in others. Self-awareness and the development of self-esteem may be a related area of development where some delays or differences are noted. The very severe emotional disorders of childhood such as childhood schizophrenia and autism may effect additional areas of development including: 1) the sequence and rate at which the child achieves certain developmental milestones; 2) speech and language development; and 3) the way the child uses his or her body.

NOTES

2 MODULE

WHO ARE THE CHILDREN?

V. FACILITATING LEARNING IN INTEGRATED SETTINGS

#13

KEY IDEA: Young children, regardless of whether there is a disability or not, can benefit from a program that is based on developmentally appropriate practices. Developmentally appropriate practices consider both the age-appropriateness and the individual appropriateness (personality, learning style, culture, etc) of learning activities. Some adaptations may have to be made to enhance the learning of young children with disabilities.

#14

#9

A. Developmentally Appropriate Practices

Developmentally appropriate practices (Bredekamp, 1987) considers both the age-appropriateness and individual appropriateness (personality, learning style, culture, etc) of learning activities. The teacher's role is to facilitate learning through child-initiated and directed play. The teacher can question, suggest or offer new challenges to help facilitate learning. Some of the basic components of developmentally appropriate practices include:

1. Curriculum

☆ All areas of a child's development, including physical, cognitive, social, emotional, and communication, should be addressed in an integrated fashion in a developmentally appropriate curriculum. Developmental assessments of the child's performance should be used to match the curriculum to the child's needs in each area.

☆ The curriculum should be appropriate for each child's developmental abilities and interests. The curriculum should incorporate a variety of materials at various levels of complexity. Care should be taken to insure that curricula are multicultural and nonsexist and support individual differences in children.

☆ Young children learn through active exploration of materials and interaction with adults and children. Activities and materials should be real objects and should allow children an opportunity to touch and manipulate. The curriculum should also allow children an opportunity to choose activities, materials, and the length of time they wish to spend interacting with materials, adults and children.

2. The Teacher's Role in Facilitating Learning

☆ The teacher should respond to the child's messages, needs and desires in a manner that is appropriate to the child's age, abilities and style. The responses should be direct and should provide the student with immediate feedback.

☆ The teacher should provide many opportunities for the child to initiate communication with both adults and peers. The teacher should also provide ample opportunities for the child to respond to a variety of communication situations.

☆ The teacher should assist the child in developing both self-esteem and self-control. This can be facilitated by respecting and accepting the child's behavior and by treating them with dignity. Clear, consistent, fair disciplinary strategies should be incorporated. In addition, the teacher should be careful to note any signs of stress from the child and to implement strategies to decrease stress when noted.

3. The Teacher's Role in Working with Families

☆ Teachers should involve family members as partners in decisions about their child's education and care. Teachers should maintain frequent contacts with families and should encourage families to participate as much as the families wish in their child's program. Teachers should be a resource for families on child development issues. Parents should be encouraged to observe and participate in the program at a variety of levels.

☆ All of the agencies and programs who have educational responsibilities for a child at different times, should share developmental information about the child and collaborate in the development of the education program. The family is key in the collaboration effort and in the dissemination of information.

B. Enhancing Learning for Children

A variety of strategies may be effective in enhancing the learning environment for young children with disabilities. It is important to examine the strengths and needs of each student and to identify their individual needs for adapting and enhancing activities. Several strategies are described below for each of the four learning characteristics.

2 MODULE

WHO ARE THE CHILDREN?

1. Sensing

☆ When talking to the child use language that is clear and understandable, even if an alternative communication system is being used. Use directions that are simple while still encouraging the child to think and learn.

☆ Allow the child to use all their senses to explore their environment. Use concrete experiences that allow the child to smell, hear, touch and taste.

☆ Model or demonstrate activities that may rely heavily on verbal explanations.

☆ Use visual material to enhance activities that rely heavily on listening skills. A few simple pictures can be used to enhance a story or music activity.

☆ Encourage the child with a hearing impairment to use as much of his/her residual hearing as possible.

☆ If the child wears a hearing aide understand how it operates. Remember that a hearing aid amplifies all sounds in an environment, not just the sounds that are important. Learn to check the hearing aid daily to see if it is working properly.

☆ If the environment is particularly noisy, use carpets, heavy curtains, or thick materials on the walls and floors to cut down on noise. Try to avoid placing noisy, distracting activities next to quieter one.

☆ Provide the child with physical impairments an opportunity to experience a variety of positions: sitting on the floor, sitting at a table, laying down, standing at the sand table, etc.

☆ Adapt activities and materials so that the child with physical impairments can interact with them. Many simple manipulative toys can be adapted for switch activation.

☆ Encourage children with visual impairments to use as much of their residual vision as possible. The idea "If you use it, you will lose it," is a myth.

☆ When presenting objects visually to the child, make sure they are in a position where the child has best vision.

☆ Vision may change from day to day depending on factors such as lighting or fatigue. Be aware that this change may occur; you may see inconsistent behavior as a result.

☆ Some children with visual impairments need extra light, others are sensitive to light. Adjust the lighting in the room as necessary.

2. Processing

- ☆ Provide students with frequent opportunities for practice and learning. Provide opportunities for a variety of activities that range form simple concrete experiences to more abstract problem solving.
- ☆ Identify specific teaching strategies based on the child's needs and abilities. Use multiple strategies during each activity to adapt for all needs.
- ☆ Provide integrated learning opportunities that address many developmental areas.
- ☆ Break large activities and tasks into small parts that may be more easily understood. Activities should use actual materials and objects to facilitate learning.
- ☆ Allow for time differences that may be needed by different children in order to complete an activity.
- ☆ Use consistent daily routines. Routines will help the child to anticipate events and will provide the child with an opportunity to communicate.
- ☆ Give the child clear warning of an impending transition. Help him/her to think about readying for the transition, walk with the child or assign a partner to assist.
- ☆ Physical contact may be used to provide support, guidance, and encouragement. Children with emotional disturbances often benefit from being physically "moved through" an activity initially and benefit from the expressed affection that a hug can provide.
- ☆ Rely on the experience and expertise of all team members, especially the parent for suggestions on how to adapt classroom activities.

3. Responding

- ☆ Encourage the development of communication skills through speech or other special means. If the child uses a method of communication other than speech, become familiar with that method.
- ☆ Encourage the child to communicate about his/her environment. Encourage communication with peers.
- ☆ Be a good listener. Listen carefully to what is being said and praise the child for trying to talk. Give the child opportunities to speak without interruption or pressure. Model relaxed, calm, and clear speech.
- ☆ Encourage the child to initiate communication. Ask the child to bring special things from home and provide an opportunity to talk about them individually or with the group. Encourage and listen as the child talks about his/her feelings.

☆ Build in regularly scheduled routines that will allow the child to anticipate and talk about upcoming events. Plan activities to provide subjects for conversation.

☆ Build opportunities for choices into activities. Ask the child to choose what toy to play with, what seat to sit in, or what color of paint to use. Later, ask the child to talk about on what they did that day.

☆ Ask open-ended rather than yes-no questions to encourage longer sentences and phrases from the child.

☆ Expand the child's speech by using descriptive new words and grammatical structures.

☆ Play listening games that will teach the child to recognize the source of a sound and to discriminate between sounds that are the same or different.

☆ Arrange the classroom space to provide ample room to accommodate the equipment the child uses for mobility. Make sure the child can move from one area to another.

☆ Arrange the physical environment so that the child with vision impairments can clearly see all obstacles. Orient the child to his/her environment and if changes occur in the environment, remember to explain them to the child.

☆ Toys and materials should be accessible to the child with physical impairments. Place items on shelves within reach. Provide the child with a way to carry items from one area to another.

4. Motivation

☆ Plan activities to maximize the child's success. Identify activities, objects, and persons who are motivating to the young child.

☆ Model a positive and caring approach toward all children. Provide extrinsic reinforcers by praising and child.

☆ Provide children with opportunities to control their environment. Provide choices to the child throughout the day. Be prepared to carry through with a choice if given to the child.

☆ Set clear limits for all children. Whatever behavioral and safety limits are set, be consistent in enforcing and modeling them.

☆ Insure safety in all activities. As children learn that they are in a safe environment, they will have more comfort in exploring and learning.

VI. CLOSING DISCUSSION

#10

A. Journal

Ask participants to take five minutes to make an entry into their journal. The entry should relate to their own thoughts and feelings related to the information and ideas discussed in the workshop.

#15

B. Review Field Exercises

Review possible field exercises for participants. Offer the option to do another activity related to the topic. Make sure that participants understand the activities and their responsibilities in completing them.

#16

C. Review Participant and Trainer Expectations and Themes

The purpose of this discussion to review the participant and trainer expectations to ensure that all training needs have been addressed.

1. Select a typical early childhood activity. Identify child behaviors that are needed to participate in the activity. Identify those adaptations the adult will have to make in order to allow a child with disabilities to participate in the activity.

2. Interview a parent of a child with disabilities. What are some of the adaptations the parent makes during everyday activities? What are some of the activities the parent would like his/her child to be doing in an early childhood settings?

3. Develop a list of questions to ask a parent of a child with disabilities who is enrolling his/her child in a child care setting. What kind of information is needed by the child care provider, family, and support service provided?

4. Generate individual or team field excercises.

D. Review Future Sessions

Review the next module for participants. Go over content and format.

E. Workshop Evaluation

Ask participants to complete the workshop evaluation for module two.

2 MODULE

WHO ARE THE CHILDREN?

VII. WORKSHOP EVALUATION

Code: ______________________ Date: ______________________

Training Site: ____

Please read each of the following statements carefully and rate each statement using the following codes:

1= Strongly Disagree (SD)
2= Disagree (D)
3= Undecided (U)
4= Agree (A)
5= Strongly Agree (SA)

	(SD)	(D)	(U)	(A)	(SA)
1. Overall, the content of this workshop met my expectations.	1	2	3	4	5
2. I gained new knowledge as a result of this workshop.	1	2	3	4	5
3. The workshop was organized and well structured.	1	2	3	4	5
4. I was provided an opportunity to discuss the ideas presented in the workshop.	1	2	3	4	5
5. I was provided with an opportunity to interact with fellow participants.	1	2	3	4	5
6. I gained knowledge about how children learn and what they know.	1	2	3	4	5
7. The workshop provided useful information on the issues surrounding the use of labels with young children with disabilities.	1	2	3	4	5
8. I gained knowledge about the effects of child characteristics on learning.	1	2	3	4	5
9. I gained knowledge about strategies to facilitate learning in integrated settings.	1	2	3	4	5

WHO ARE THE CHILDREN?

10. Please identify three of the most significant things you learned as a result of this workshop.

1. ______________________________

2. ______________________________

3. ______________________________

11. What were the strengths of this workshop?

____

12. In what ways could this workshop be improved?

____

13. What follow-up needs do you have, if any?

____

2 MODULE

WHO ARE THE CHILDREN?

VIII. TRAINING ACTIVITIES

The following training activities are designed to be used during the second module. For each activity, the Trainer has been provided with the purpose of the activity, a description of the activity, the length of time the activity takes, the materials needed and the recommended audience size for the activity. A different activity may be substituted as long as it meets the intended purposes of the original activity.

ACTIVITIES **PAGE**

1. **A Child's Perception of the World** 26
2. **Vignettes** 37
3. **Personal Experiences** 43
4. **Child Development Activity** 44
5. **Toy Activity** 49
6. **IQ Test** 50
7. **Label Headbands** 69
8. **Impact on Learning** 70
9. **Developmentally Appropriate Practices: How Am I Doing?** 73
10. **Adaptations Activities** 79
11. **Barrier Identification** 83

2 MODULE

WHO ARE THE CHILDREN?

ACTIVITY #1

A CHILD'S PERCEPTION OF THE WORLD

LENGTH OF ACTIVITY

15
minutes

Materials:

Overhead projector and overhead transparencies

Audience:

Large group

Reprinted with permission from: *The New Friends Training Manual*, Chapel Hill Training - Outreach, Chapel Hill, North Carolina.

Purpose: To provide participants with information and an opportunity to discuss the perceptions of a young child and how these perceptions effect his/her development

Description:

1. Present each overhead transparency and briefly describe the overhead. Refer participants to their copies of the overheads as each is presented. You may color the overhead to make them more visually appealing.

2. Generate discussion with participants about each overhead. Questions that may be used to generate discussion include:

   a. Have you ever experienced this type of reaction from a child? How old was the child?

   b. What are some clues that the child may not be perceiving the situation in the same way that the adult perceives it?

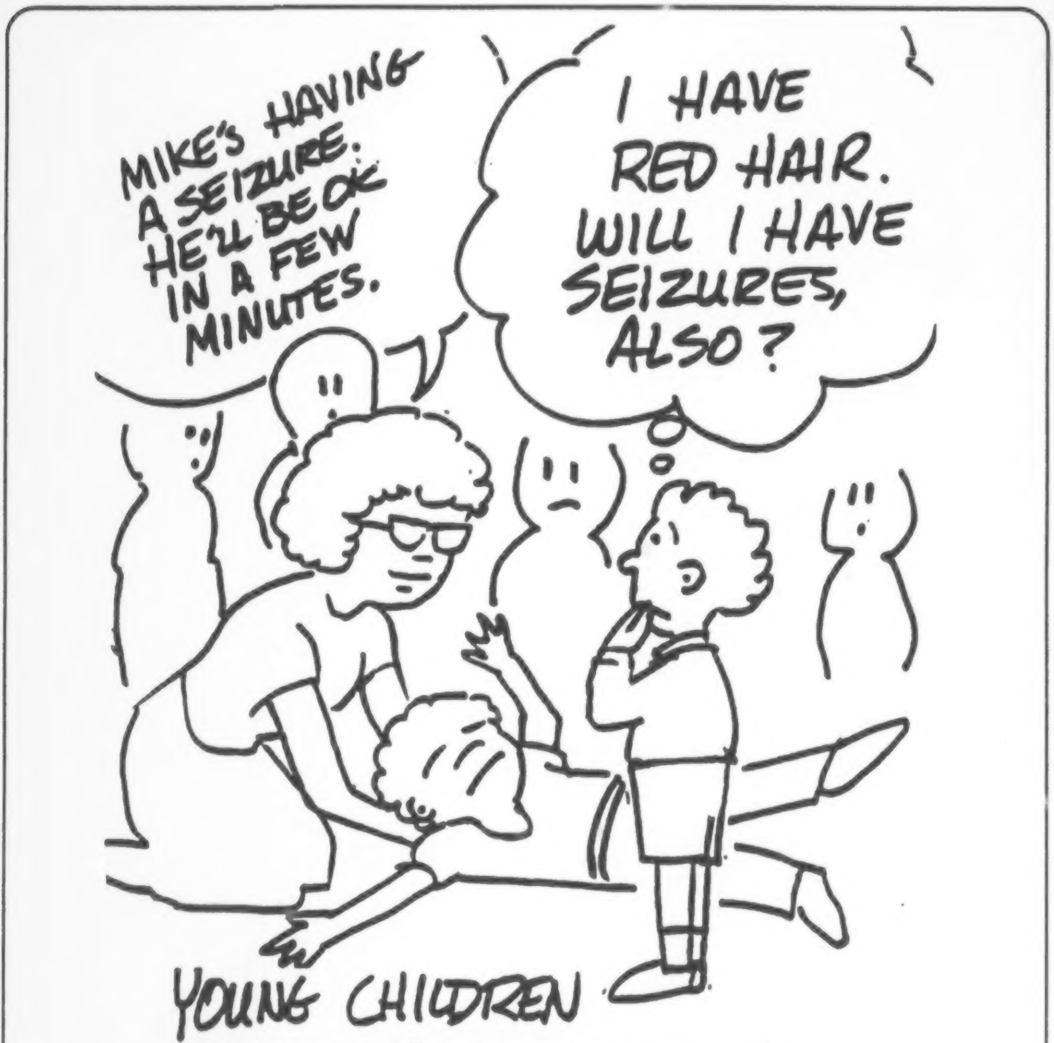
   c. What might the adult do to help the child understand the situation?

Additional Strategies:

ACTIVITY #1

OVERHEAD: A CHILD'S PERCEPTION OF THE WORLD

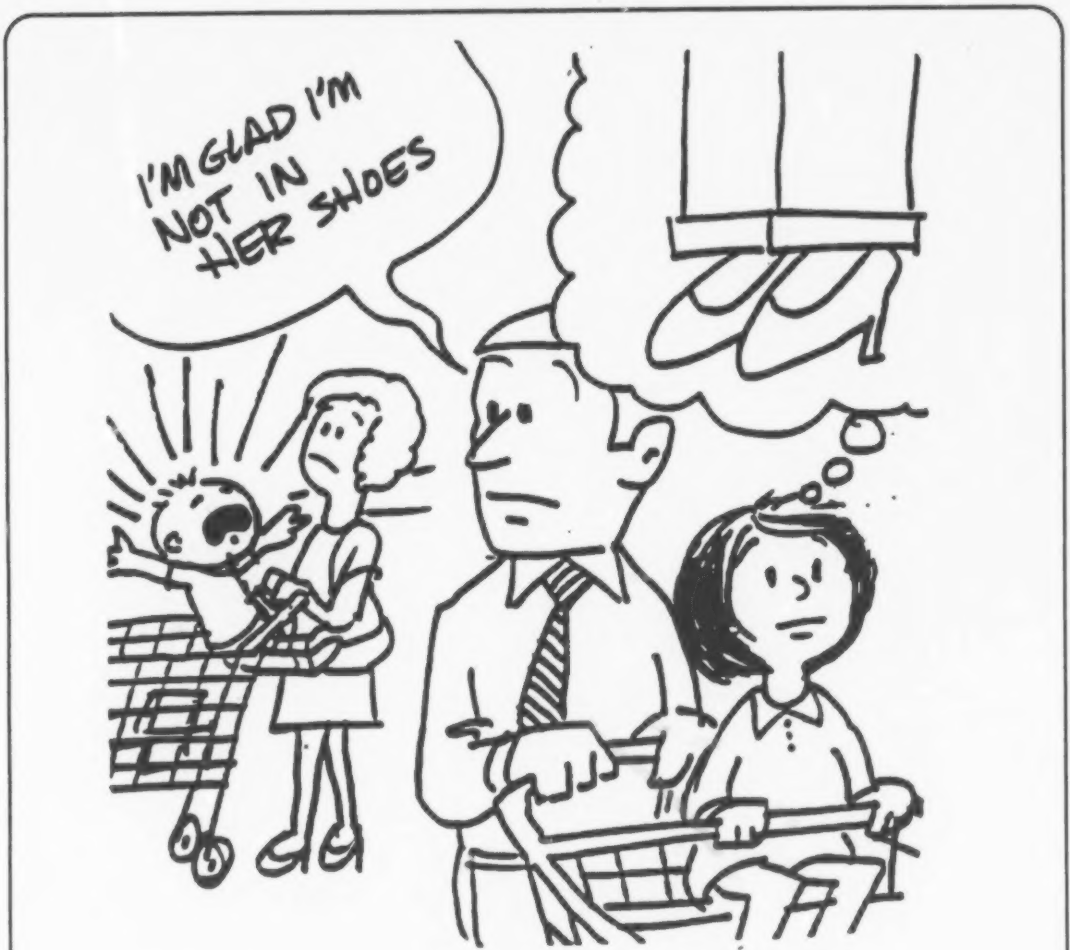
RED HAIR


MIKE'S HAVING A SEIZURE. HE'LL BE OK IN A FEW MINUTES.
I HAVE RED HAIR. WILL I HAVE SEIZURES, ALSO?
YOUNG CHILDREN TEND TO PARTICULARIZE.

ACTIVITY #1

OVERHEAD: A CHILD'S PERCEPTION OF THE WORLD

THINK CONCRETELY

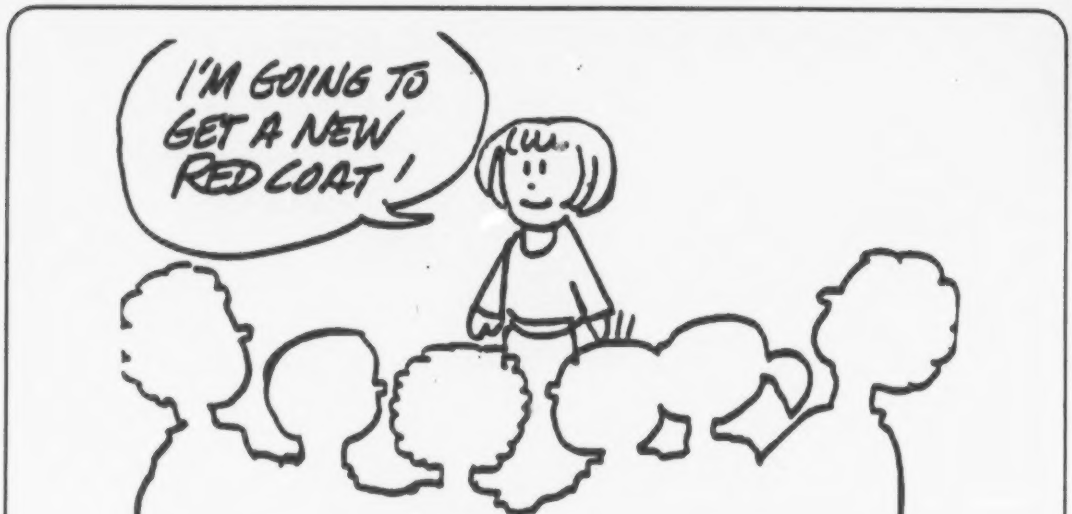

I'M GLAD I'M NOT IN HER SHOES

YOUNG CHILDREN THINK CONCRETELY.

ACTIVITY #1

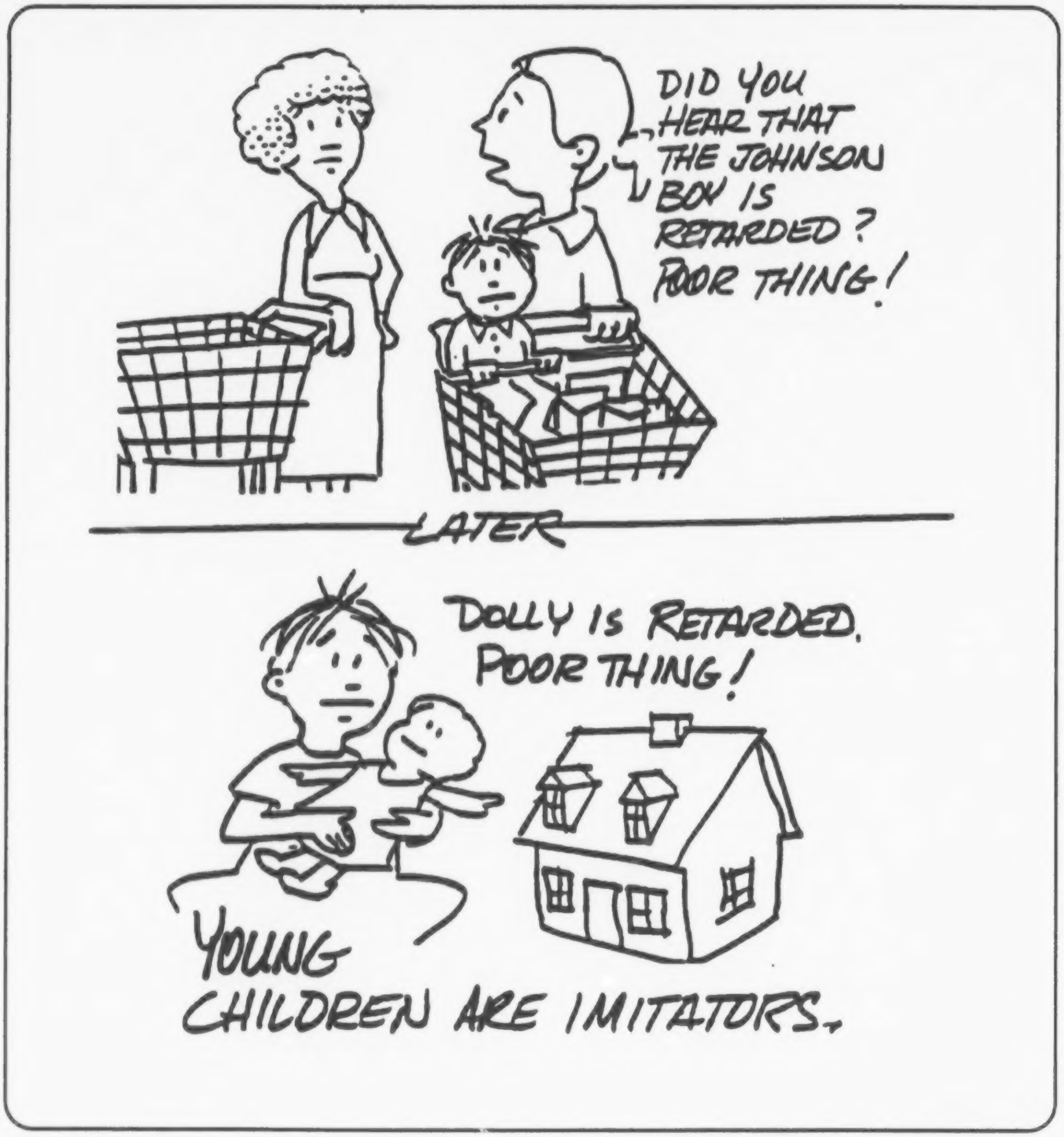
OVERHEAD: A CHILD'S PERCEPTION OF THE WORLD

EGOCENTRIC


I'M GOING TO GET A NEW RED COAT!
I AM, TOO!
YOUNG CHILDREN ARE EGOCENTRIC.

ACTIVITY #1 | **OVERHEAD: A CHILD'S PERCEPTION OF THE WORLD**

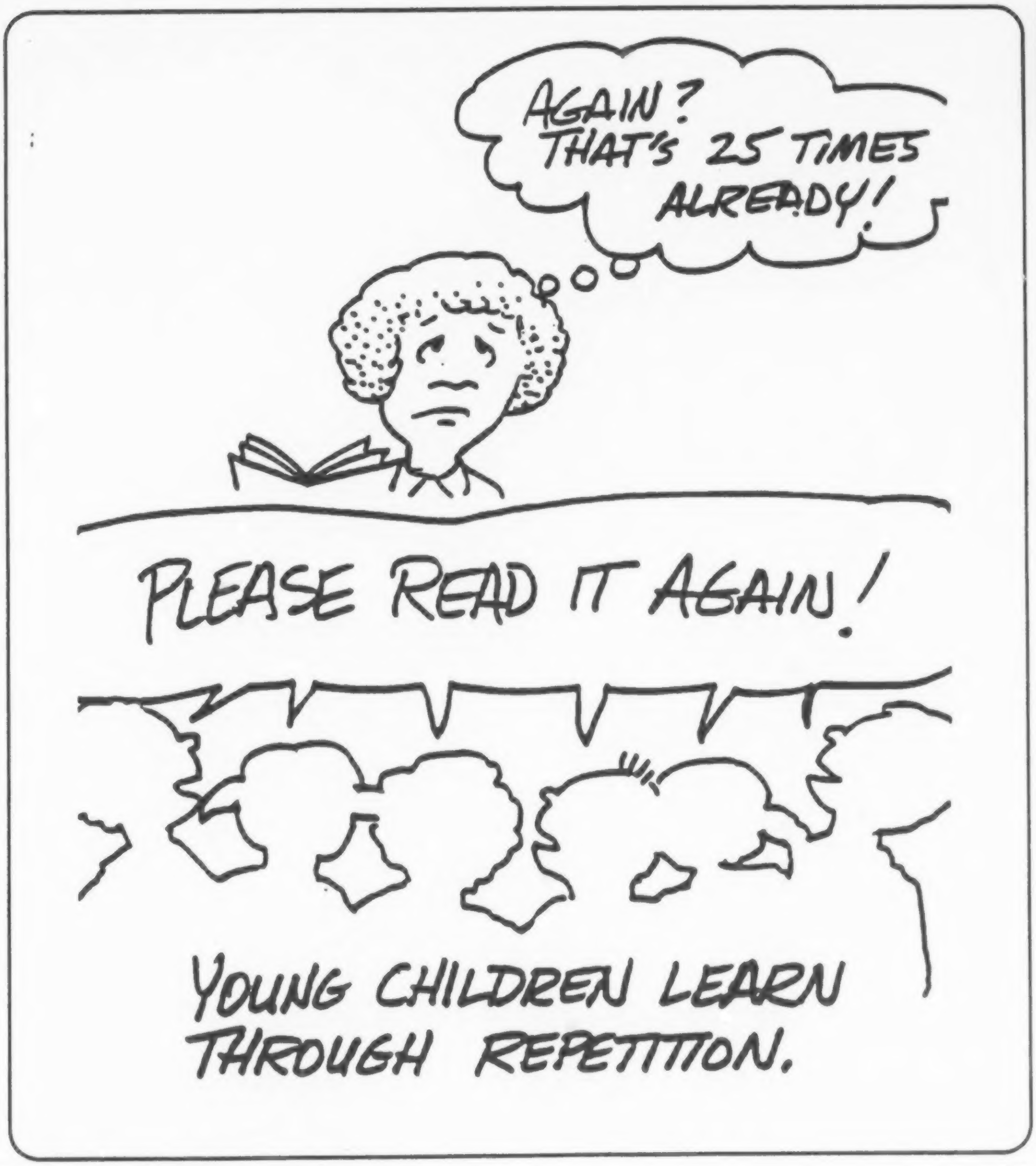
IMITATORS


DID YOU HEAR THAT THE JOHNSON BOY IS RETARDED? POOR THING!
LATER
DOLLY IS RETARDED. POOR THING!
YOUNG CHILDREN ARE IMITATORS.

ACTIVITY #1

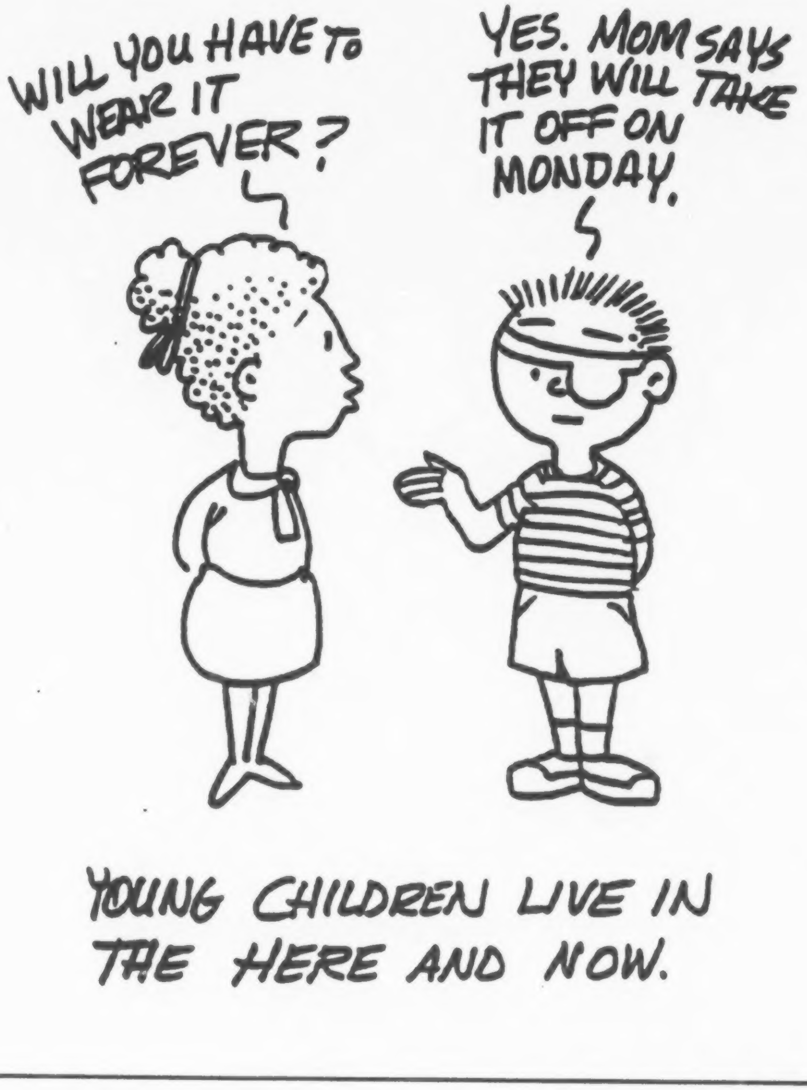
OVERHEAD: A CHILD'S PERCEPTION OF THE WORLD

REPETITION


AGAIN? THAT'S 25 TIMES ALREADY!
PLEASE READ IT AGAIN!
YOUNG CHILDREN LEARN THROUGH REPETITION.

ACTIVITY #1 | **OVERHEAD: A CHILD'S PERCEPTION OF THE WORLD**

HERE AND NOW

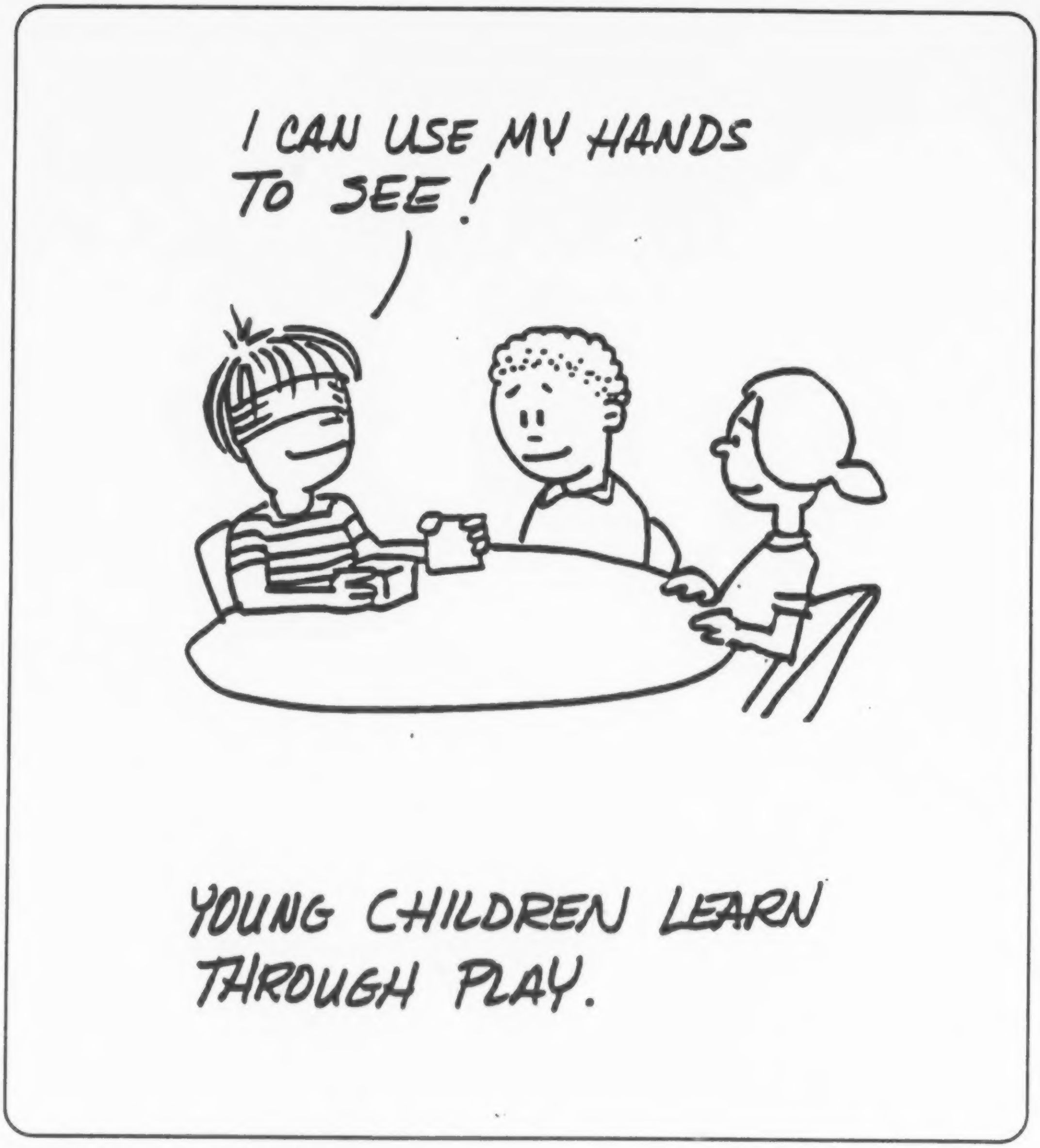

WILL YOU HAVE TO WEAR IT FOREVER?
YES. MOM SAYS THEY WILL TAKE IT OFF ON MONDAY.

YOUNG CHILDREN LIVE IN THE HERE AND NOW.

ACTIVITY #1

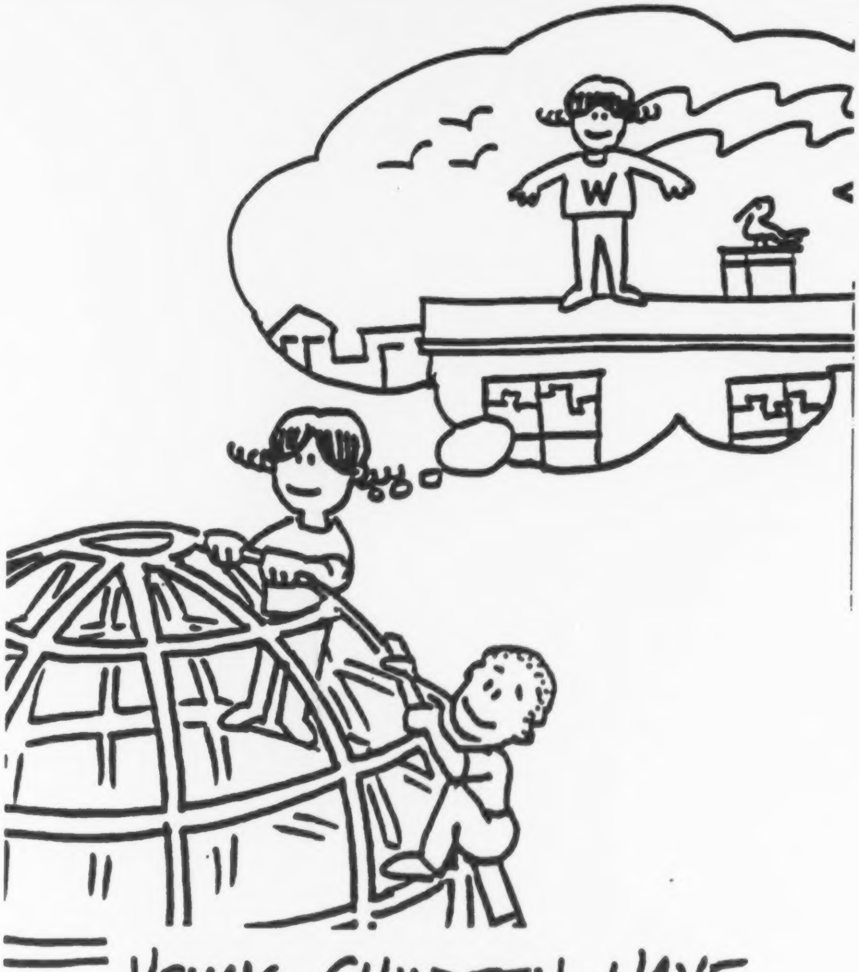
OVERHEAD: A CHILD'S PERCEPTION OF THE WORLD

LEARN THRU PLAY


I CAN USE MY HANDS TO SEE!
YOUNG CHILDREN LEARN THROUGH PLAY.

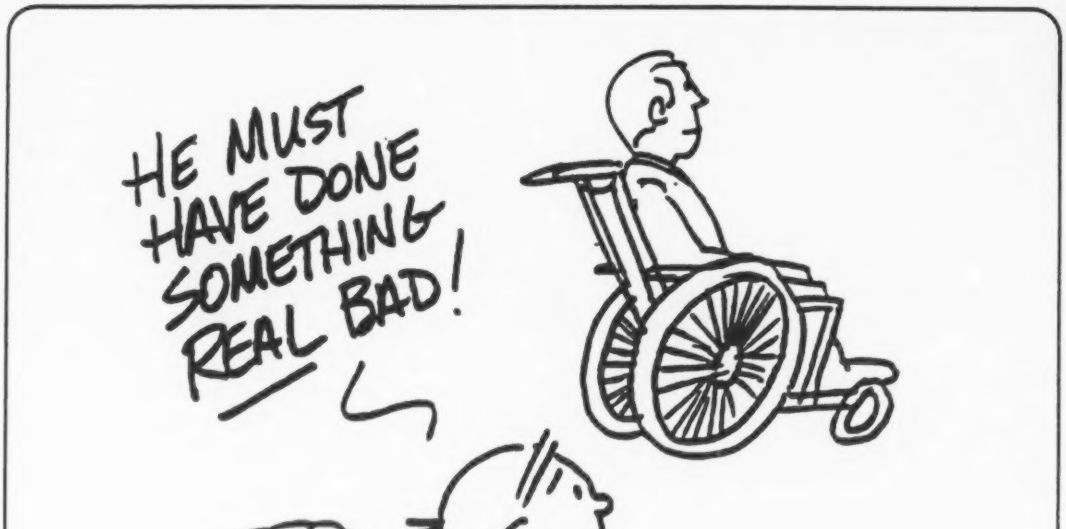
ACTIVITY #1 **OVERHEAD: A CHILD'S PERCEPTION OF THE WORLD**

RICH FANTASY LIVES



YOUNG CHILDREN HAVE RICH FANTASY LIVES.

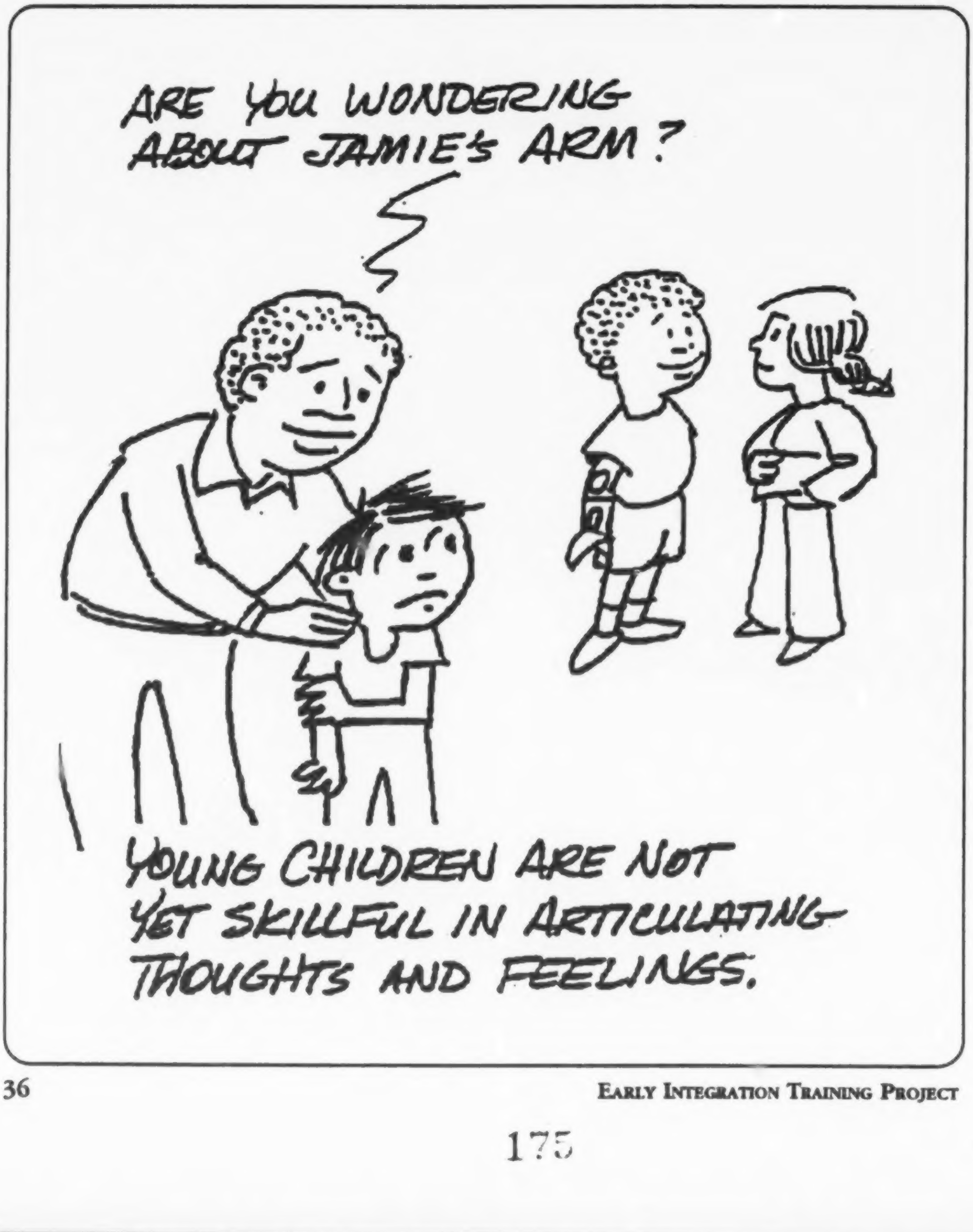
WHEELCHAIR


HE MUST HAVE DONE SOMETHING REAL BAD!
YOUNG CHILDREN ARE BEGINING TO MAKE CAUSE AND EFFECT RELATIONSHIPS.

ACTIVITY #1

OVERHEAD: A CHILD'S PERCEPTION OF THE WORLD

JAMIE'S ARM


ARE YOU WONDERING ABOUT JAMIE'S ARM?
YOUNG CHILDREN ARE NOT YET SKILLFUL IN ARTICULATING THOUGHTS AND FEELINGS.

ACTIVITY #2

VIGNETTES

LENGTH OF ACTIVITY

30 *minutes*

Purpose: a. To make participants aware of the potential reactions young children may have to their peers with disabilities.

b. To provide participants with the opportunity to discuss the perceptions of young children.

Description:

1. Divide participants into an even number of small groups, with 4 -5 participants in each group. Participants should identify one person in each group to record the group's responses.

2. Give each group a copy of one of the two Vignettes. Each participant in the group should get a copy. The trainer should inform the participants that the vignettes are based on **real**, not hypothetical, experiences.

3. Ask each group to discuss what the child was feeling and thinking about each situation.

   a. How could the teacher have facilitated the situation?

   b. What things could have been done to prepare the child?

4. Allow groups to present their responses to the larger group. Compare the comments from each group with the same Vignette.

5. As time allows, have participants, as a small group, respond to the second Vignette. Share responses as a large group.

Additional Strategies:

Materials:

Copies of the Vignettes for each participant and one copy of each Vignette as an overhead transparency.

Audience:

Small and large group

ACTIVITY #2

VIGNETTE #1

A CHILD'S PERCEPTIONS OF A PEER WITH A DISABILITY

A CHILD WITH AUTISM was integrated into a day care center enrolling children ages three to five. One morning during free play the child with autism was playing near the record player, swooping down toward the spinning record occasionally, jumping in place, thumping his chest repeatedly with his fist making grimaces and occasionally a low sound. A young three year old boy was noticed, sitting on the little rug in the area where the "manipulative" toys were kept on open shelves, staring intently and looking somewhat frightened by the behavior. The consultant or "resource teacher" noticing this, eased next to the young child, who, it turned out, was new at the center, and said, "I notice you looking at Justin and it looks as though you are worried. He is jumping up and down a lot and making faces isn't he?" The little boy nodded vigorously. "That's the way Justin enjoys the music," the resource teacher continued. "It looks a little different doesn't it, but he won't hurt you. The teacher knows he enjoys music this way and he does some other things a little differently as well." One might think the resource teacher was making more of this than need be if one believes that children are really very accepting and don't notice differences. It is the behavior that followed that suggested that this young child, coping with the newness of the day care center to begin with, felt worried and possibly unsafe. He stuck like glue to the resource teacher for the remainder of the morning. The tragedy of this situation was that the resource teacher was a consultant and not a regular member of the staff. The solution for this was for the resource teacher or the consultant to pass on her observation to the child's teacher so that the person with whom he either had a relationship or at least the adult who would be there all day to help him, could be the one to reach out to him and assure him at this time.

ACTIVITY #2

VIGNETTE #2

A CHILD'S PERCEPTIONS OF A PEER WITH A DISABILITY

A CHILD WITH CEREBRAL PALSY was enrolled in a large child care setting. She used a walker to get around the classroom and although cognitively age appropriate, had some facial and arm involvement and was unsteady walking and sitting. The teacher in the class had been well prepared; had developed a plan with the help of the parent and had visited the special school where the child had been receiving services. The resource teacher (consultant) had visited the setting a number of times to talk with all the teachers. The second day all the children were arranged in small armless chairs in a semi-circle to listen to a story. The child with Cerebral Palsy went to sit down and losing her balance tipped toward the child next to her bracing herself by putting her hand on his knee. A terrified look came across his face and he frantically brushed her hand away with both hands. The consultant or resource teacher was nearby and was quickly able to say to the child with cerebral palsy, "Donald is frightened isn't he? I think he is worried by the fact that you use a walker to walk. Is that right Donald?" Donald nodded, wide-eyed. "Perhaps he doesn't know that you were born with legs that don't work as well as his. Perhaps he thinks if you touch him his legs won't work either. Donald, this won't happen to you. Marissa was born this way. Her walker gives her the help she needs to walk." Evidence that this was effective and on target was observed in Donald's behaviors. Never again did he avoid or seem frightened by Marissa or by her walker.

NOTE: Although the teacher had been prepared the children had only been told a new child who would use a walker would be coming. There needs to be an atmosphere developed in which children feel free to ask questions. Also, as much as possible, the teacher or the adult in the class with whom the children have a trusting relationship needs to be the one who is aware of and can respond to children's apprehensions.

ACTIVITY #3

PERSONAL EXPERIENCES

Length of Activity

15
minutes

Materials:

None

Audience:

Large group discussion

Purpose: To provide a format for participants to discuss their experiences and knowledge about the development of young children without disabilities.

Description:

1. Ask participant to describe one experience with a young child that highlighted a particular developmental stage.

   a. What observations did you make about the child that gave you insight into the child's behavior?

   b. What observations did you make about the child that provided you with information about the child's developmental abilities?

2. Ask participants to describe the various things that children do at different ages. Try to focus on the different activities that children enjoy at different ages.

   a. What do the different activities tell you about the child's developmental skills?

   b. What are the different expectations for children at different ages?

Additional Strategies:

ACTIVITY #4

CHILD DEVELOPMENT ACTIVITY

LENGTH OF ACTIVITY

30
minutes

Materials:

One copy of the handout for each group

Audience:

Small and large group

Purpose: a. To provide participants with an opportunity to discuss the developmental skills and abilities of young children of different ages.

b. To provide participants with information about a variety of early childhood activities and their appropriateness for children of different ages.

Description:

1. Divide participants into small groups. A recorder should be determined for each group. Each recorder should receive one copy of the Child Development Activity handout.

2. Ask each group to choose a particular early childhood activity. The groups should try to be as specific as possible about the activity.

3. For each age group, ask participants to:

   a. Identify if the activity is appropriate for the age group. If the activity is not appropriate, the group should identify how it might be adapted.
   b. Identify what skills and abilities can be expected from a child at that age.

4. As a large group, ask participants to discuss their ideas.

5. Collect each of the Child Development Activity forms. Make copies of each form for dissemination to participants.

Additional Strategies:

ACTIVITY #4

HANDOUT: CHILD DEVELOPMENT ACTIVITY

Activity:

12-18 mos:

18-24 mos:

24-30 mos:

30-36 mos:

36-48 mos:

ACTIVITY #4

HANDOUT: CHILD DEVELOPMENT ACTIVITY

Activity:

4 yr olds

5 yr olds

6 yr olds

7 yr olds

8 yr olds

182

ACTIVITY #5

TOY ACTIVITY

Length of Activity

30
minutes

Materials:

One child's toy for each group. The toys should reflect a variety of ages, interests and abilities.

Audience:

Small and large group

Purpose: To provide participants with an understanding of the different skills and abilities that young children have at different ages.

Description:

1. Give each group of participants a child's toy. Ask each group to brainstorm on all the possible activities that can be done with that toy. Participants should identify the developmental ages that would be the most beneficial for each of the toys.

2. As a large group, ask participants to categorize the toys and activities by ages.

   a. What toys and activities are appropriate for different ages?

   b. How can children of different ages interact with the same toy?

Additional Strategies:

ACTIVITY #6 — IQ TEST

Length of Activity

30 minutes

Materials:

A copy of the IQ test form for each participant, (Please note that there are four different test forms), one answer key, and enough animal pictures for each participant.

Audience:

Individual and large group

Purpose: To provide participants with an awareness of the feelings associated with labeling.

Description:

1. The trainer should set the environment so that it is similar to an extreme testing situation. Participants should be asked to remove all books and papers and to move away from their neighbors.

2. Pass out a test form to each participant taking care to pass out different formats to neighboring participants. Tell participants that they will be taking a timed test. Participants will have three minutes to complete the entire test. Instruct participants to begin, and begin timing the test.

3. Upon completion, provide participants with answers, by letter only, of each of the items. Ask participants to determine the number of answers they got wrong.

4. Pass out animal pictures to participants based on scores. Participants with the most items incorrect receive turkeys, next number of wrong items receive turtles, next receive elephants, and the participants with the highest scores receive tigers. Participants may be required to wear their "label" for the rest of the session. The trainer may also wish to group participants in the room according to categories with the tigers in the best locations.

5. Lead a discussion with the participants to identify their feelings about being given a particular label.

Purpose: To provide participants with an awareness of the feelings associated with labeling.

Reprinted with permission from: The Cincinnati Center for Developmental Disabilities, Cincinnati, OH

ACTIVITY #6

HANDOUT: IQ TEST

HOW DOES IT FEEL AND WHAT DOES IT MEAN TO BE HANDICAPPED?
THE I.M.I.U. NATIONALLY STANDARDIZED INTELLIGENCE TEST

1. The following is a color:

   a. fish
   b. car
   c. stove
   d. blue

2. The following was not a President of the United States:

   a. John Kennedy
   b. Benjamin Franklin
   c. George Washington
   d. William Taft

3. 9 x 7 =

   a. 27
   b. 97
   c. 63
   d. 67

4. How many inches are in a foot?

   a. 12
   b. 3
   c. 36
   d. 18

5. The following is not a planet?

   a. Mars
   b. Jupiter
   c. Hamilton
   d. Saturn

6. When riding a bicycle at night, you should:

   a. wear dark clothing and sunglasses
   b. ride on the other side of the road, opposite the side for day riding
   c. wear a white shirt or coat, turn on bicycle head and tail lamp
   d. don't ride at night

ACTIVITY #6 HANDOUT: IQ TEST

7. The Goldberg Variations are:

   a. differences in genetic make-up
   b. piano compositions by Bach
   c. differences in selected musical keys
   d. mutations of external limbs

8. Gravure is:

   a. a process in printing
   b. an ancient burial ground
   c. intellectual conversation
   d. any matter of importance

9. The term "Dorian" refers to:

   a. Greek column style
   b. a shade of gray
   c. a psychoanlytic procedure
   d. musical style prevalent in the Middle Ages

10. Ram is to mar as step is to:

   a. crush
   b. break
   c. pets
   d. part

11. A chain has 5 links. The first link can hold 7 pounds. The second can hold 9 pounds. The third can hold 4 pounds. The fourth can hold 8 pounds. The last can hold 7 pounds. How many pounds can the whole chain hold?

   a. 9 pounds
   b. 7 pounds
   c. 8 pounds
   d. 4 pounds
   e. 35 pounds

ACTIVITY #6

HANDOUT: IQ TEST

12. The "henry" is:

    a. a unit of measurment of inductance
    b. a unit of resistance
    c. volt equivalent
    d. a chemical substance

13. "Alnico" is:

    a. a skin disease
    b. a type of mental illness
    c. an engineering term
    d. a precious metal
    e. an alloy used for magnets

14. The term "joule" refers to:

    a. a musical instrument
    b. tempo
    c. a unit of energy
    d. a carpenter's tool
    e. a type of electrical wire

15. Kirchoff is well known for his contribution to the field of:

    a. music
    b. psychology
    c. electronics
    d. economics
    e. education

16. A dentist would:

    a. deliver a baby
    b. prescribe sunglasses
    c. perform a heart transplant
    d. pull a tooth

HANDOUT: IQ TEST

17. Milk could be purchased at:

    a. a grocery store
    b. a hardware store
    c. a florist
    d. a clothing store

18. A sick animal would be cared for by:

    a. a pediatician
    b. an optomologist
    c. a veterinarian
    d. a podiatrist

19. The following would be used to mend clothes:

    a. a nail
    b. a staple
    c. a tack
    d. thread

20. The following be worn for snow skiing:

    a. wing tips
    b. boots
    c. sneakers
    d. sandles

21. The following is used to brush teeth:

    a. a shovel
    b. a hose
    c. a wrench
    d. a brush

ACTIVITY #6 **HANDOUT: IQ TEST**

HOW DOES IT FEEL AND WHAT DOES IT MEAN TO BE HANDICAPPED?
THE I.M.I.U. NATIONALLY STANDARDIZED INTELLIGENCE TEST

1. The following is a color:

   a. fish
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   a. wear dark clothing and sunglasses
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   d. don't ride at night

ACTIVITY #6

HANDOUT: IQ TEST

7. The Goldberg Variations are:

   a. differences in genetic make-up
   b. piano compositions by Bach
   c. differences in selected musical keys
   d. mutations of external limbs

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   b. an ancient burial ground
   c. intellectual conversation
   d. any matter of importance

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   b. a shade of gray
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   d. musical style prevalent in the Middle Ages

10. Ram is to mar as step is to:

   a. crush
   b. break
   c. pets
   d. part

11. A chain has 5 links. The first link can hold 7 pounds. The second can hold 9 pounds. The third can hold 4 pounds. The fourth can hold 8 pounds. The last can hold 7 pounds. How many pounds can the whole chain hold?

   a. 9 pounds
   b. 7 pounds
   c. 8 pounds
   d. 4 pounds
   e. 35 pounds

ACTIVITY #6 **HANDOUT: IQ TEST**

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    a. a unit of measurment of inductance
    b. a unit of resistance
    c. volt equivalent
    d. a chemical substance

13. "Alnico" is:

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    b. a type of mental illness
    c. an engineering term
    d. a precious metal
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    d. economics
    e. education

16. A French seam is:

    a. a machine stitch
    b. a seam within a seam
    c. a type of wood lamination
    d. a seam sewn with a double needle

ACTIVITY #6 HANDOUT: IQ TEST

17. Muntin is used in:

    a. production of a window fram
    b. food production (cooking)
    c. farming
    d. tuning

18. Cambium is:

    a. a part of an automobile engine
    b. a vitamin deficiency
    c. a part of the physical structure of a tree
    d. a musical instrument

19. The term "puzzolano" refers to:

    a. a music tempo
    b. a difficult problem
    c. a food ingredient
    d. volcanic dust

20. A "darby" is:

    a. a kitchen design
    b. a flat tool used in plastering
    c. a type of saw
    d. a type of linen
    e. a fishing lure

21. The word "pentatonic" refers to:

    a. five states of emotional behavior
    b. five types of anti-depressant medicine
    c. a play by Sophocles
    d. a five tone scale of music

ACTIVITY #6

HANDOUT: IQ TEST

HOW DOES IT FEEL AND WHAT DOES IT MEAN TO BE HANDICAPPED?
THE I.M.I.U. NATIONALLY STANDARDIZED INTELLIGENCE TEST

1. The following is a color:

   a. fish
   b. car
   c. stove
   d. blue

2. The following was not a President of the United States:

   a. John Kennedy
   b. Benjamin Franklin
   c. George Washington
   d. William Taft

3. 9 x 7 =

   a. 27
   b. 97
   c. 63
   d. 67

4. How many inches are in a foot?

   a. 12
   b. 3
   c. 36
   d. 18

5. The following is not a planet?

   a. Mars
   b. Jupiter
   c. Hamilton
   d. Saturn

6. When riding a bicycle at night, you should:

   a. wear dark clothing and sunglasses
   b. ride on the other side of the road, opposite the side for day riding
   c. wear a white shirt or coat, turn on bicycle head and tail lamp
   d. don't ride at night

ACTIVITY #6

HANDOUT: IQ TEST

7. The U.S.A. has:

   a. 48 states
   b. 50 states
   c. 52 states
   d. 45 states

8. Thomas Edison is known for:

   a. the light bulb
   b. the automobile
   c. the telephone
   d. the steam engine

9. The following state is not located in the East:

   a. Maine
   b. Florida
   c. Virginia
   d. California

10. 10 + 21 - 7 =

   a. 30
   b. 38
   c. 24
   d. 27

11. A refrigerator is used to:

   a. wash clothes
   b. cook food
   c. cut food
   d. cool food

ACTIVITY #6

HANDOUT: IQ TEST

12. The following is a bird:

    a. robin
    b. deer
    c. trout
    d. beaver

13. The following is not a form of transportation

    a. bus
    b. train
    c. airplane
    d. automobile
    e. football

14. The following is a winter month:

    a. May
    b. July
    c. December
    d. September

15. The following is an even number:

    a. 1
    b. 11
    c. 6
    d. 15

16. A dentist would:

    a. deliver a baby
    b. prescribe glasses
    c. perform a heart transplant
    d. pull a tooth

ACTIVITY #6

HANDOUT: IQ TEST

17. Milk could be purchased at:

    a. a grocery store
    b. a hardware store
    c. a florist
    d. a clothing store

18. A sick animal would be cared for by:

    a. a pediatrician
    b. an optomologist
    c. a veterinarian
    d. a podiatrist

19. The following would be used to mend clothes:

    a. a nail
    b. a staple
    c. a tack
    d. thread

20. The following be worn for snow skiing:

    a. wing tips
    b. boots
    c. sneakers
    d. sandles

21. The following is used to brush teeth:

    a. a shovel
    b. a hose
    c. a wrench
    d. a brush

ACTIVITY #6 **HANDOUT: IQ TEST**

HOW DOES IT FEEL AND WHAT DOES IT MEAN TO BE HANDICAPPED?
THE I.M.I.U. NATIONALLY STANDARDIZED INTELLIGENCE TEST

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ACTIVITY #6

HANDOUT: IQ TEST

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   c. 24
   d. 27

11. A refrigerator is used to:

   a. wash clothes
   b. cook food
   c. cut food
   d. cool food

ACTIVITY #6 HANDOUT: IQ TEST

12. The "henry" is:

    a. a unit of measurment of inductance
    b. a unit of resistance
    c. volt equivalent
    d. a chemical substance

13. "Alnico" is:

    a. a skin disease
    b. a type of mental illness
    c. an engineering term
    d. a precious metal
    e. an alloy used for magnets

14. The term "joule" refers to:

    a. a musical instrument
    b. tempo
    c. a unit of energy
    d. a carpenter's tool
    e. a type of electrical wire

15. Kirchoff is well known for his contribution to the field of:

    a. music
    b. psychology
    c. electronics
    d. economics
    e. education

16. A dentist would:

    a. deliver a baby
    b. prescribe sunglasses
    c. perform a heart transplant
    d. pull a tooth

ACTIVITY #6

HANDOUT: IQ TEST

17. Milk could be purchased at:
    - a. a grocery store
    - b. a hardware store
    - c. a florist
    - d. a clothing store

18. A sick animal would be cared for by:
    - a. a pediatrician
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    - a. a shovel
    - b. a hose
    - c. a wrench
    - d. a brush

ACTIVITY #6

IQ TEST

I.M.I.U. NATIONALLY STANDARDIZED INTELLIGENCE TEST KEY

1. D
2. B
3. C
4. A
5. C
6. C
7. B
8. A
9. D
10. C
11. D
12. A
13. E
14. C
15. C
16. D
17. A
18. C
19. D
20. B
21. D

ACTIVITY #7

LABEL HEADBANDS

Length of Activity

20
minutes

Materials:
One head band for each participant. On each head band should be a label that is commonly found in special education. The labels should represent a range of aversive connotations. Examples include: mentally retarded, autistic, gifted, infectious disease carrier, severe behavior problem, etc..

Audience:
Large group

Purpose: To provide participants with an awareness of the feelings associated with labeling.

Description:

1. At the beginning of the session, provide each participant with a labeled head band The participants should not know what label is on their head band.

2. Participants should be instructed to wear the head bands throughout the session. Participants should respond to each other according to the label.

3. At the end of the session, ask participants to discuss how they felt when they were wearing the label. Could the participants guess what their label was?

Additional Strategies:

ACTIVITY #8

IMPACT ON LEARNING

Length of Activity

30
minutes

Materials:

One copy of the handout for participant, one copy of handout as overhead

Audience:

Large or small group

Purpose: a. To provide participants with information about the impact of different child centered learning characteristics on development

b. To discuss young children with disabilities and their relationship to the four child centered learning characteristics

Description:

1. If the entire group is fairly small this activity may be done with the entire group. If needed, divide participants into smaller groups. Each participant should have a copy of the handout.

2. For each of the four learning characteristics, ask participants to answer the following two questions. Answers should be recorded in the space beneath each characteristics. The answers to each questions may be noted in different colors.
   - ☆ If a child was having difficulty using this learning characteristic, what behaviors might you expect to be seen?
   - ☆ If a child was having difficulty using this learning characteristic, what labels might the child be given?

3. As a large group, review the participants responses to the questions. Try to focus the second question on those labels that may be given to children who may not have a specific disability (e.g., shy, lazy, over-achiever, etc.).

4. Ask participants to reflect back on the use of labels to identify young children. Ask "Do the labels provide useful information?"

Additional Strategies:

WHO ARE THE CHILDREN?

ACTIVITY #8 **HANDOUT: IMPACT ON LEARNING**

DIRECTIONS: For each of the four child centered learning characteristics, ask yourself two questions, "If a child is having difficulty with this learning characteristic, what behaviors might be seen? and "If a child was having difficulty with this learning characteristics, what labels might be given?" Record your responses in the space provided below.

	BEHAVIOR	LABEL
SENSING Acuity and efficiency of sensory abilities including auditory, visual, gustatory, tactile, and olfactory.		
PROCESSING Learning strategies such as selective attention, concept formation, and memory strategies.		
RESPONDING Observable behaviors the child produces in response to a situation or sensory experience.		
MOTIVATION Intrinsic and extrinsic reinforcers that impact on the child's interest in learning.		

ACTIVITY #9

DEVELOPMENTALLY APPROPRIATE PRACTICES: HOW AM I DOING?

LENGTH OF ACTIVITY

20
minutes

Materials:

One *"How Am I Doing?"* form for each participant

Audience:

Individual and large group

Purpose: To assist participants in identifying the developmentally appropriate practices that they are currently using.

Description:

1. Individually, each participant should complete the "How Am I Doing?" form.

2. As a large group, participants should be encouraged to share their responses. The trainer should focus the discussion on strategies to increase the participants' use of developmentally appropriate practices.

Additional Strategies:

ACTIVITY #9

HANDOUT- HOW AM I DOING?

DIRECTIONS:
For each item, rate yourself on how well you use these teaching strategies in your interactions with young children and their families. If you are a parent, rate how well your child's educational program does on each of the items. Rate each item from 1 ("I don't use this strategy at all.") to 6 ("I use this strategy all the time.") by circling the appropriate number. In the comments section, discuss ways to increase your use of the teaching strategy.

1. I use activities that integrate all areas of a child's development: physical, cognitive, social, emotional, and communication.

I don't use this strategy at all				I use this strategy all the time.	
1	2	3	4	5	6

Comments: ______________________________

____

2. I take care to insure that activities and materials are multicultural and nonsexist and support individual differences in children.

I don't use this strategy at all				I use this strategy all the time.	
1	2	3	4	5	6

Comments: ______________________________

____

3. I use activities and materials that use real objects and allow children an opportunity to touch and manipulate.

I don't use this strategy at all				I use this strategy all the time.	
1	2	3	4	5	6

Comments: ______________________________

____

ACTIVITY #9 **HANDOUT- HOW AM I DOING?**

4. I respond to each child's messages, needs and desires in a manner that is appropriate to the child's age, abilities and style.

I don't use this strategy at all					I use this strategy all the time.
1	2	3	4	5	6

Comments: ____________________

____

5. I provide ample opportunities for the child to initiate and respond to a variety of communication situations.

I don't use this strategy at all					I use this strategy all the time.
1	2	3	4	5	6

Comments: ____________________

____

6. I assist each child in developing both self-esteem and self-control.

I don't use this strategy at all					I use this strategy all the time.
1	2	3	4	5	6

Comments: ____________________

____

7. I involve family members as partners in decisions about their child's education and care.

I don't use this strategy at all					I use this strategy all the time.
1	2	3	4	5	6

Comments: ____________________

____

ACTIVITY #10

ADAPTATIONS ACTIVITIES

Length of Activity

30 minutes

Audience:

Small and large group

Purpose: To provide participants with an opportunity to identify potential teaching strategies to adapt classroom activities for young children with disabilities.

Materials: One copy of the Adaptations Activity form for each group, one 3 x 5 index card with a learning difficulty written on it. Examples of learning difficultiesinclude:

- Children who have difficulty moving
- Children who have difficulty using their hands
- Children who have difficulty learning things quickly
- Children who have difficulty learning things visually
- Children who have difficulty paying attention
- Children who have difficulty communicating what they need
- Children who have difficulty in appropriately expressing feelings
- Children who have difficulty listening

Description:

1. Divide participants into small groups. A recorder should be determined for each group. Each recorder should receive one copy of the Adaptations Activity form. Each group should also be given a card with a specific learning difficulty identified.

ADAPTATIONS

Adaptions for a child who has difficulty:

Activity to be Adapted:

ACTIVITY #11

BARRIER IDENTIFICATION

LENGTH OF ACTIVITY

15 *minutes*

Materials:

Post-it® notes or index cards and tape

Audience:

Large group discussion

Purpose: a. To provide participants with an opportunity to discuss potential barriers to providing integrated settings in their own communities.

b. To provide participants with an opportunity to generate potential solutions to identified barriers.

Description:

1. Fasten barriers from the previous session(s) to the wall or bulletin board. Review these barriers. Ask participants to identify any barriers that have been resolved as a result of information received during the training. Move those barriers that have been resolved to a different section of the wall or bulletin board.
2. Facilitate a brainstorming discussion of additional potential barriers to integration.
3. Write each identified barrier on an index card as participants generate them. Tape or fasten each barrier to the wall. If solutions are generated to the barriers, write them down on the appropriate index card.
4. Review the barriers generated during the previous sessions.
5. At the end of the session, the trainer should collect the cards for the next session.
6. The trainer may wish to use the following list of potential barriers if participants have difficulty identifying barriers or seem to miss what might be key barriers.

ACTIVITY #11

BARRIER IDENTIFICATION

A. **Personal Barriers:** Those barriers that relate specifically to the individuals involved in integrating a young child with disabilities into an early childhood setting. The barriers are related to the staff and the child with disabilities.

1. Attitudes of Staff Concerning Children with Disabilities: Staff may not feel comfortable with the idea of integrating a young child with disabilities into an early childhood setting. Other staff may feel comfortable with some children with disabilities but not with others. Comments such as "He'll be a bad influence on the other children," or "She has too many motor difficulties to be in my classroom," or "He is too disabled to be in that setting," may be a key to identifying these barriers.

2. Attitudes of Staff Concerning Potential Role Changes: Integrating young children with disabilities into early childhood settings may involve role changes for both early childhood educators and support service staff. Some staff may be reluctant to make the changes that will be necessary to insure that the integration of the young child with disabilities is successful. Changes will have to be made where staff work, how staff work and what staff do with children. These changes may bring out a sense of territorialism in staff that can be a barrier to integration.

3. Qualifications of Staff: Staff may not feel qualified to work with young children with disabilities in integrated settings. This may only be a barrier if the staff is unwilling or unable to develop additional skills and knowledge. Barriers may also occur if staff is unwilling to cross-train in their area of expertise.

Changes will have to be made where staff work, how staff work and what staff do with children. These changes may bring out a sense of territorialism is staff that can be a barrier to integration.

B. **Programmatic Barriers:** Programmatic barriers relate to the setting where the integration is to occur. Barriers to integration may exist because of the building, people who interact with the child with disabilities and with the changes in programming and staffing that may be needed to fully support integration.

1. Physical Plant Barriers: Barriers may exist that limit integration because of the physical structure of the building or classroom. Examples of these barriers include: stairs for a child who is nonambulatory, poor acoustical environments for a child with a hearing impairment or a child who can not tolerate noise, or lack of adequate lighting for a child with visual impairments.

2. Attitudes of Persons in the Environment Toward Children with Disabilities: Other staff, families, and peers may present barriers to integration if care is not taken to prepare them for the integration of a young child with disabilities. Comments such as "I don't want him in my child's class," may be identified as barriers to integration.

3. Changes in Programming: Changes in the way both early childhood personnel and support service personnel work may be necessary. Although staff may be willing to make these changes, the changes may not be supported by the programs/agencies that provide services to young children with disabilities. Barriers may occur if agencies are not willing to make changes in staffing patterns, roles and responsibilities to meet changes in programming. Barriers may also include funding sources, liability issues and transportation issues.

C. **Community Barriers:** Other barriers exist that are not under the control of the staff or the program/agency where they work. These barriers relate to the community as a whole. Some of these barriers may include: the rules and regulations of both child care and special education services including certification issues, the availability of programs and services, and issues related to liability, funding and transportation at the community level.

2 MODULE

WHO ARE THE CHILDREN?

IX. OVERHEAD TRANSPARENCIES

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1. Module Two: Outline of Training 87
2. Module Two: Purpose 89
3. Module Two: Goals 91
4. Module Two: Participant and Trainer Expectations 93
5. Key Idea: How Do Children Learn? 95
6. Child Characteristics that Impact Learning 97
7. What Do Children Do? 99
8. Key Idea: Child Characteristics that Impact Learning 101
9. Issues Related to the Use of Labels 103
10. Issues Related to the Use of Labels 105
11. Respecting Diversity in Others Through Language 107
12. The Effects of Child Characteristics on Early Development 109
13. Key Idea: Facilitating Learning in Integrated Settings 111
14. Facilitating Learning in Integrated Settings 113
15. Field Exercises 115

1

Module Two: Who Are the Children?

- Outline of Module
  - How Do Children Learn?
  - Child Characteristics That Impact Learning
  - Facilitating Learning In Integrated Settings

Module Two: Purpose

- Purpose: to provide information on the abilities and needs of young children with and without disabliities

3

Module Two: Goals

- To provide information on the individual needs and abilities of all children individually and in groups
- To provide information on the impact of disability on early childhood development
- To provide information on teaching strategies for young children with and without disabilities

Module Two: Participant & Trainer Expectations

- The Trainer will provide participants with the:
  - information to be able to describe one area of development of young children
  - information to be able to describe some of the issues involved in labeling children according to disabilities
  - information to be able to describe the impact of a particular disability on early childhood development
  - information to be able to explore feelings, values, and attitudes about disabilities in young children with disabilities

5 Key Idea: How Do Children Learn?

- How a child learns is impacted by many factors. Some of these factors are related to the learning environment, while others are related to individual child characteristics. Important child characteristics that can be impacted includ: sensory abilities; processing abilities; ability to respond to the invironment; and motivation. While all children show variability across these four factors, there is still much consistency in the general progrsession of child development.

2 Overhead Transparencies

6

Child Characteristics that Impact Learning

- Sensing
- Processing
- Responding
- Motivation

7 What Do Children Do?

- Variability in Development
- Holistic Approach
- Effects of Individual Development on Group Situations

8 Key Idea: Child Characteristics that Impact Learning

- It is not necessary and is very impractical for all adults to know everything about disability. It is more important to have a basic understanding of the potential effects tht some child characteristics may have on normal early childhood development.
- Children with the same disability label do not have the same skills and abilities. In fact, they are often more different than they are alike. Children with disabilities are not very different from children without labeled disabilities.

9

Issues Related to the Use of Labels

- Children with the same label are often dramatically different from one another because each disability label is used to describe a range of developmental impact.
- People are often tempted to predict the future for young children based on a diagnostic label.
- Labels may not be vary accurate due to difficulties in testing young children.
- All children with a specific disability label do not benefit from the same educational strategies.
- A label may reflect only one area of need and therefore, the child may not receive all the services that are needed.

10

Issues Related to the Use of Labels

- When a particular label is attached to the child, certain limits are created with little expectations of changing outcomes.
- Labels direct our attention to the disability of the child, rather than the child's ability.
- Labels can keep children from being included in regular early childhood activities
- Labels tend to follow children for the rest of their lives, even when a disability no longer exists.

11 Respecting Diversity in Others Through Language

- People First Language
- Children with Disabilities vs. Disabled Children

12 The Effects of Child Characteristics on Early Development

- Sensing
- Processing
- Responding
- Motivation

13 Key Idea: Facilitating Learning in Integrated Settings

- Young children, regardless of whether there is a disability or not, can benefit from a program that is based on developmentally appropriate practices. Developmentally appropriate practices consider both the age-appropriateness and the individual appropriateness (personality, learning style, culture, etc) of learning activities. Some adaptations may have to be made to enhance the learning of young children with disabilities.

14 Facilitating Learning in Integrated Settings

- Developmentally Appropriate Practices
- Enhancing Learning for Children

15 Field Excercises

- Select a typical early childhood activity. Identify child behaviors that are needed to participate in the activity. Identify those adaptations the adult will have to make in order to allow a child with disabilities to participate in the activity.
- Interview a parent of a child with disabilities. What are some of the adaptations the parent makes during everyday activities? What are some of the activities the parent would like his/her child to be doing in an early childhood settings?
- Develop a list of questions to ask a parent of a child with disabilities who is enrolling his/her child in a child care settting. What kind of information is needed by the child care provider, family, and support service provider?
- Generate individual or team field exercises.

WHO ARE THE CHILDREN?

X. SUMMARY PAPERS

TITLE: **PAGE**

1. Developmental Milestone Chart 118
2. NAEYC Best Practices: Integrated Components of Develop mentally Appropriate Practice for Infants and Toddlers 126
3. Basic Ideas About Early Childhood and Young Children with Disabilities 149
4. Children with Cognitive Impairments 151
5. Children with Hearing Impairments 153
6. Children with Multiple Impairments 155
7. Children who have Physical and Health Impairments 157
8. Children who have Social and Emotional Disabilities 159
9. Children who have Speech and Language Impairments 161
10. Children with Vision Impairments 163

DEVELOPMENTAL MILESTONE CHARTS

	Interest in others	Self awareness	Motor milestones and eye-hand skills
The Early Months (birth through 8 months)	Newborns prefer the human face and human sound. Within the first 2 weeks, they recognize and prefer the sight, smell, and sound of the principal caregiver. Social smile and mutual gazing is evidence of early social interaction. The infant can initiate and terminate these interactions. Anticipates being lifted or fed and moves body to participate. Sees adults as objects of interest and novelty. Seeks out adults for play. Stretches arms to be taken.	Sucks fingers or hand fortuitously. Observes own hands. Places hand up as an object comes close to the face as if to protect self. Looks to the place on body where being touched. Reaches for and grasps toys. Clasps hands together and fingers them. Tries to cause things to happen. Begins to distinguish friends from strangers. Shows preference for being held by familiar people.	The young infant uses many complex reflexes: searches for something to suck; holds on when falling; turns head to avoid obstruction of breathing; avoids brightness, strong smells, and pain. Puts hand or object in mouth. Begins reaching toward interesting objects. Grasps, releases, regrasps, and releases object again. Lifts head. Holds head up. Sits up without support. Rolls over. Transfers and manipulates objects with hands. Crawls.
Crawlers & Walkers (8 to 18 months)	Exhibits anxious behavior around unfamiliar adults. Enjoys exploring objects with another as the basis for establishing relationships. Gets others to do things for child's pleasure (wind up toys, read books, get dolls). Shows considerable interest in peers. Demonstrates intense attention to adult language.	Knows own name. Smiles or plays with self in mirror. Uses large and small muscles to explore confidently when a sense of security is offered by presence of caregiver. Frequently checks for caregiver's presence. Has heightened awareness of opportunities to make things happen, yet limited awareness of responsibility for own actions. Indicates strong sense of self through assertiveness. Directs actions of others (e.g., "Sit there!"). Identifies one or more body parts. Begins to use me, you, I.	Sits well in chairs. Pulls self up, stands holding furniture. Walks when led. Walks alone. Throws objects. Climbs stairs. Uses marker on paper. Stoops, trots, can walk backward a few steps.

DEVELOPMENTAL MILESTONE CHART

	Language development/ communication	Physical, patial, and temporal awareness	Purposeful action and use of tools	Expression of feelings
The Early Months (birth through 8 months)	Cries to signal pain or distress. Smiles or vocalizes to initiate social contact. Responds to human voices. Gazes at faces. Uses vocal and nonvocal communication to express interest and exert influence. Babbles using all types of sounds. Engages in private conversations when alone. Combines babbles. Understands names of familiar people and objects. Laughs. Listens to conversations.	Comforts self by sucking thumb or finding pacifier. Follows a slowly moving object with eyes. Reaches and grasps toys. Looks for dropped toy. Identifies objects from various viewpoints. Finds a toy hidden under a blanket when placed there while watching.	Observes own hands. Grasps rattle when hand and rattle are both in view. Hits or kicks an object to make a pleasing sight or sound continue. Tries to resume a knee ride by bouncing to get adult started again.	Expresses discomfort and comfort/pleasure unambiguously. Responds with more anima-tion and pleasure to primary caregiver than to others. Can usually be comforted by familiar adult when distressed. Smiles and activates the ob- vious pleasure in response to social stimulation. Very inter- ested in people. Shows dis- pleasure at loss of social contact. Laughs aloud (belly laugh). Shows displeasure or disappointment at loss of toy. Expresses several clearly differentiated emotions: pleasure, anger, anxiety or fear, sadness, joy, excitement, disappointment, exuberance. Reacts to strangers with soberness or anxiety.
Crawlers & Walkers (8 to 18 months)	Understands many more words than can say. Looks toward 20 or more objects when named. Creates long babbled sentences. Shakes head no. Says 2 or 3 clear words. Looks at picture books with interest, points to objects. Uses vocal signals other than crying to gain assistance. Begins to use me, you, I.	Tries to build with blocks. If toy is hidden under 1 of 3 cloths while child watches, looks under the right cloth for the toy. Persists in a search for a desired toy even when toy is hidden under distracting objects such as pillows. When chasing a ball that rolled under sofa and out the other side, will make a detour around sofa to get ball. Pushes foot into shoe, arm into sleeve.	When a toy winds down, continues the activity manually. Uses a stick as a tool to obtain a toy. When a music box winds down, searches for the key to wind it up again. Brings a stool to use for reaching for something. Pushes away someone or something not wanted. Feeds self finger food (bits of fruit, crackers). Creeps or walks to get something or avoid unpleasantness. Pushes foot into shoe, arm into sleeve. Partially feeds self with fingers or spoon. Handles cup well with minimal spilling. Handles spoon well for self-feeding.	Actively shows affection for familiar person: hugs, smiles at, runs toward, leans against, and so forth. Shows anxiety at separation from primary caregiver. Shows anger focused on people or objects. Expresses negative feelings. Shows pride and pleasure in new accomplishments. Shows intense feelings for parents. Continues to show pleasure in mastery. Asserts self, indicating strong sense of self.

2 MODULE

WHO ARE THE CHILDREN?

DEVELOPMENTAL MILESTONES

	Interest in others	Self awareness	Motor milestones and eye-hand skills
Toddlers & 2 Year-Olds (18 months to 3 years)	Shows increased awareness of being seen and evaluated by others. Sees others as a barrier to immediate gratification. Begins to realize others have rights and privileges. Gains greater enjoyment from peer play and joint exploration. Begins to see benefits of cooperation. Identifies self with children of same age or sex. Is more aware of the feelings of others. Exhibits more impulse control and self-regulation in relation to others. Enjoys small group activities.	Shows strong sense of self as an individual, as evidenced by "NO" to adult requests. Experiences self as a powerful, potent, creative doer. Explores everything. Becomes capable of self-evaluation and has beginning notions of self (good, bad, attractive, ugly). Makes attempts at self-regulation. Uses names of self and others. Identifies 6 or more body parts.	Scribbles with marker or crayon. Walks up and down stairs. Can jump off one step. Kicks a ball. Stands on one foot. Threads beads. Draws a circle. Stands and walks on tiptoes. Walks up stairs one foot on each step. Handles scissors. Imitates a horizontal crayon stroke.
3 Year-Olds	Joins in interactive play with other children. Begins to interact. Shares toys. Takes turns with assistance. Begins dramatic play (acting out scenes: playing house, pretending to be an animal). Learns through observing and imitating adults. Easily distracted. Short attention span. Responds to social contact made by familiar adults.	Knows own name. Knows own age. Toilets independently. Some independent self-hygiene: •blows nose •washes hands Calls attention to his/her performance. Knows whether he/she is male/female. Demonstrates caution and avoids common dangers.	Uses slide (without assistance). Throws ball overhanded. Catches ball bounced to him/her. Copies a verticle line. Copies a circle. Imitates cross. Uses scissors to cut. Turns pages of a book individually.

2 MODULE

WHO ARE THE CHILDREN?

	DEVELOPMENTAL MILESTONES			
	Language development/ communication	**Physical, patial, and temporal awareness**	**Purposeful action and use of tools**	**Expression of feelings**
Toddlers & 2 Year-Olds (18 months to 3 years)	Combines words. Listens to stories for a short while. Speaking vocabulary may reach 200 words. Develops fantasy in language. Begins to play pretend games. Defines use of many household items. Uses compound sentences. Uses adjectives and adverbs. Recounts events of the day.	Identifies a familiar object by touch when placed in a bag with 2 other objects. Uses "tomorrow," "yesterday." Figures out which child is missing by looking at children who are present. Asserts independence: "Me do it." Puts on simple garments such as cap or slippers.	When playing with a ring-stacking toy, ignores any forms that have no hole. Stacks only rings or other objects with holes. Classifies, labels, and sorts objects by group (hard versus soft, large versus small). Helps dress and undress self.	Frequently displays aggressive feelings and behaviors. Exhibits contrasting states and mood shifts (stubborn versus compliant). Shows increased fearfulness (dark, monsters, etc.). Expresses emotions with increasing control. Aware of own feelings and those of others. Shows pride in creation and production. Verbalizes feelings more often. Expresses feelings in symbolic play. Shows empathic concern for others.
3 Year-Olds	Begins to understand sentences involving time concepts. Understands size comparatives such as big and bigger. Understands relationships (if-then). Tells about past experiences. Uses "s" on nouns with plurals. Uses "ed" on verbs for past tense. Refers to self as "I" or "me". Uses sentences with three plus words: •agent-action objects •agent-action loacation	Runs around obstacles. Walks on a line. Balances on one foot for 5 - seconds. Jumps over small object landing on both feet.	Pushes, pulls, steers wheeled toys. Rides (pedals and steers) tricycle. Hammers nails and pegs. Manipulates clay materials, example: •rolls balls •rolls snakes •makes cookies	Expresses enthusiasm for work or play. Shows sympathy toward others.

DEVELOPMENTAL MILESTONES: MOTOR/EYE-HAND SKILLS

	Interest in others	Self awareness	Motor milestones and eye-hand skills
4 Year-Olds	Plays and interacts with other children (cooperating). Dramatic play is close to reality. Chooses his/her own friends. Cooperates in group activities. Responds to instruction given in small groups and initiates appropriate task without being reminded. Takes turns and shares.	Knows own street and town. Asserts self in socially acceptable ways. Asks permission to use others' property. Recognizes anothers's needs for help and gives assistance.	Jumps forward 10 times. Walks up and down stairs with alternating feet. Turns somersault. Cuts on a line. Copies cross. Copies square. Prints a few capital letters.
5 Year-Olds	Plays competitive games. Engages with other children in cooperative play involving: •group decisions •role assignments •"fair play" Learns through instruction (via adult). When interested can ignore distractions. Uses peers as resources. Shows ideas with peers.	Dresses self completely. Relates clock time to daily schedule. Begins to understand why things happen (beyond self). Seeks alternatives without adult assistance. Copes with criticism and awareness. Begins to be critical of own workmanship.	Runs. Hops. Skips (alternating feet). Jumps rope. Skates. Hand-dominance established. Draws person. Draws recognizable shapes.

DEVELOPMENTAL MILESTONES: MOTOR/EYE-HAND SKILLS

	Language development/ communication	Physical, patial, and temporal awareness	Purposeful action and use of tools	Expression of feelings
4 Year-Olds	Follows 3 unrelated commands in order. Understands comparatives (pretty, prettier, prettiest). Asks "wh" questions (when, how, why). Uses verbal models. Joins sentences together. Talks about causality.	Walks backward-toe to heel	Laces shows. Opens small padlock with keys.	Comforts peers in distress. Describes his/her feelings. Has special friends. Recognizes facial expressions of primary emotions.
5 Year-Olds	Gives and receives information. Takes turns appropriately in conversation. Communicates well.	Walks on balance beam. Colors within lines. Begins to use accurate time concepts.	Uses "classroom" tools appropriately: •scissors •paints •pencils (with adult grasp) •assembles simple puzzles	Demonstrates a "positive" attitude. Recognizes feelings of others. Descriminates between socially acceptable versus nonacceptable behaviors.

	[redacted]	[redacted]	
	Interest in others	**Self awareness**	**Motor milestones and eye-hand skills**
6 Year-Olds	Intensely interested in conduct of peers. Engages in small group activities. Shows interest in group approval. Shows strong sense of justice and sense of right and wrong.	Begins to eternalize moral rules of behavior and is acquiring a conscience though may be inconsistent in following these rules. Blows nose independently. Brushes hair removing tangles.	Ties bowknot. Buttons back bbuttons. Ties apron or dress sash in front. Snaps back snaps. Gallops. Accomplished at skipping and kicking. Catches ball in flight. Prints letters with some reversals.
7 Year-Olds	Learning to evaluate achievements of others.	Prepares water for bath or shower. Follows tooth brushing routine. Concerned with own lack of skill and achievement. Becoming more realistic and less imaginative. Learning to evaluate personal achievements.	Rides bicycle. Large muscle activity predominates in interest and value though endurance may be fairly low. More improvement in eye-hand coordination. Throwing and catching becoming more accurate.
8 Year-Olds	Has special friends. Does not like playing alone. Shows interest in joining clubs.	Washes ears. Bathes when reminded. Grooms nails. Appreciates correct skill performance.	Ties apron or dress sash in back. Writes sentences. Interested in games using small muscles.

WHO ARE THE CHILDREN?

	Language development/ communication	Physical, patial, and temporal awareness	Purposeful action and use of tools	Expression of feelings
6 Year-Olds	Has speaking vocabulary of about 2500 words. Has listening vocabulary of about 800 words. Can define objects in terms of function. Contributes personal experiences and	Demonstrates accurate, distant and directional throwing. Washes hands at appropriate times. Knows right and left side	Spreads with knife.	May have difficaly controlling anger. May show unpredictable or explosive behavior. Shows mix of jealousy and pride toward siblings. May be self-assertive and dramatic. Is often restless and may have difficulty making dicisions. Is greatly excited by new things.
7 Year-Olds	Conversations often center around family. Abstract thinking is beginning. Still has fairly short attention span	Printing letters with few reversals Attaining orientation in time.	Cuts with knife. Reads books by self.	Difficulty taking adult criticism. Values independence. Overanxious to reach adult goals. Sensitive to failure and self-critical. Less impulsice and boisterous. Stands up for own rights. May have nervous habits.
8 Year-Olds	Likes to memorize. Control over phoneme production so few articulation errors.	Can tell day of month and year Aware of time though still developing time telling ability.	Leaves many tasks uncompleted. Starts collection. Enjoys dramatizing	Can give and take peer criticism. Does not like to be treated as a child. Shows marked sense of humor. First impulse is ti blame others.

2 Summary Papers

NAEYC Best Practices

Integrated Components of Developmentally Appropriate Practice for Infants and Toddlers

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In Part 2 of this book, the National Center for Clinical Infant Programs and NAEYC describe the vital development that takes place during the first 3 years of life and give examples of appropriate care of infants and toddlers. Building on the previous description of development and practice, Part 3 is designed for practitioners who care for infants or toddlers in group settings. Both appropriate and inappropriate practices are described here, because people often understand a concept most clearly if they are presented positive and negative examples.

Because all areas of development are thoroughly integrated during early childhood, the title for these descriptions refers to integrated components. The components of practice that are referred to in this section parallel the comparison of a group as described in NAEYC's Accreditation Criteria and Procedures of the National Academy of Early Childhood Programs. It is hoped that the descriptions of appropriate and inappropriate practices that follow will help directors and teachers to interpret and apply the accreditation Criteria to their work with infants and toddlers.

Because development is so individual, these statements do not define infants and toddlers by chronological age. For the purpose of clarity, the infant statement is directed toward the care of non-walking children and the toddler statement addresses caring for children from the time they are walking until they are between 2 1/2 and 3-years-old.

Integrated Components of APPROPRIATE and INAPPROPRIATE Practice for *INFANTS*

Component	**APPROPRIATE Practice**	**INAPPROPRIATE Practice**
Interactions among adults and children	• Adults engage in many one-to-one, face-to-face interactions with infants. Adults talk in a pleasant, soothing voice, and use simple language and frequent eye contact.	• Infants are left for long periods in cribs, playpens, or seats without adult attention. Adults are harsh, shout, or use baby talk.
	• Infants are held and carried frequently to provide them with a wide variety of experiences. The adults talk to the infant before, during, and after moving the infant around.	• Infants are wordlessly moved about at the adult's convenience. Nothing is explained to infants.
	• Adults are especially attentive to infants during routines such as diaper changing, feeding, and changing clothes. The caregiver explains what will happen, what is happening, and what will happen next.	• Routines are swiftly accomplished without involving the infant. Little or no warm interactions take place during routines.
	• All interactions are characterized by gentle, supportive responses. Adults listen and respond to sounds that infants make, imitate them, and respect infants' sounds as the beginning of communication.	• Adults are rough, harsh, or ignore the child's responses.

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Interactions among adults and children (continued)	• Caregivers respond quickly to infants' cries or calls of distress, recognizing that crying and body movements are infants' only way to communicate. Responses are soothing and tender.	• Crying is ignored or respondee to irregularly at the convenience of the adult. Crying is treated as a nuisance. Adult's responses neglect the infants' needs
	• Playful interactions with babies are done in ways that are sensitive to the child's level of tolerance for physical movement, louder sounds, or other changes.	• Adults frighten, tease, or upset children with their unpredictable behaviors.
	• Children's play interests are respected. Adults observe the child's activity and comment, offer additional ideas for play, and encourage the child's engagement in the activity.	• Infants are interrupted, toys are whisked from their grasp, adults impose their own ideas or even play with toys themselves regardless of the child's interest.
	• The caregiver frequently talks with, sings to, and reads to infants. Language is a vital, lively form of communication with individuals.	• Infants are expected to entertain themselves or watch television. Language is used infrequently and vocabularies limited.
	• Infants and their parents are greeted warmly and with enthusiasm each morning. The caregiver holds the baby upon arrival and gradually helps the child become a part of the small group.	• Babies are placed on the floor or in a crib with no caregiver interaction. Caregivers receive children coldly and without individual attention.
	• Caregivers consistently respond to infants' needs for food and comfort thus enabling the infants to develop trust in the adults who care for them, so they find the world a secure place to be.	• Adults are unpredictable and/or unresponsive. They act as if children are a bother.
	• Caregivers adjust to infants' individual feeding and sleeping schedules. Their food preferences and eating styles are respected.	• Schedules are rigid and based on adults' rather that children's needs. Food is used for rewards (or denied as punishment).
	• Infants are praised for their accomplishments competent.	• Infants are criticized for what they cannot do or for their clumsy struggle to master a skill. They are made to feel inadequate and that they have no effect on others.
	• Teacher respect infant's curiosity about each other. At the same time, adults help ensure that children treat each other gently.	• Infants are not allowed to touch each other gently, or are forced to share or play together when they have no interest in doing so.
	• Adults model the type of interactions with others that they want children to develop.	• Adults are aggressive, shout, or exhibit a lack of coping behaviors under stress.
	• Adults frequently engage in games such as Peek-a-Boo and 5 Little Piggies with infants who are interested and responsive to the play.	• Games are imposed on children regardless of their interest. Play is seen as a time filler

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Interactions among adults and children (continued)	Diaper changing, feeding, and other routines are viewed as vital learning experiences for babies.	Routines are dealt with superficially and indifferently.
	Healthy accepting attitudes about children's bodies and their functions are expressed.	Infants are made to feel their bodies are not to be touched or admired, and that bodily functions are disgusting.
Environment	The diapering, sleeping, feeding, and play areas are separate to ensure sanitation and provide quiet, restful areas.	Areas are combined and are very noisy and distracting.
	The environment contains both soft (pillows, padded walls) and hard (rocking chairs, mirrors) elements.	The environment is either sterile or cluttered, but lacks variety.
	Babies find contrasts in color and design interesting, so bright colors are used to create distinct patterns.	Rooms are sterile and bland.
	Children have their own cribs, bedding, feeding utensils, clothing, diapers, pacifiers, and other special comforting objects. Infants' names are used to label every personal item.	Infants share sleeping quarters in shifts, or otherwise do not have their own special supplies.
	The area that is the focus of play changes periodically during the day from the floor, to strollers, to being carried, to rocking or swinging, and other variations to give infants different perspectives on people and places. Children are cared for both indoors and outdoors.	Babies are confined to cribs, playpens, or the floor for long periods indoors. Time outdoors is viewed as too much bother or is not done because of excuses about the weather.
	Mirrors are placed where infants can observe themselves-on the wall next to the floor, next to the diapering area.	Children never have a chance to see themselves.
	Fresh air and healthy heat/humidity/cooling conditions are maintained.	Rooms are too hot or too cold.
	The room is cheerful and decorated at children's eye level with pictures of people's faces, friendly animals, and other familiar objects. Pictures of children and their families are displayed.	Areas are dingy and dark. Decorations are at adult eye level and are uninteresting. No family photos are displayed.
	A variety of music is provided for enjoyment in listening/body movement/singing.	Music is used to distract or lull infants to sleep. Children hear only children's songs.
	Space is arranged so children can enjoy moments of quiet play by themselves, so they have space to roll over, and so they can crawl toward interesting objects.	Space is cramped and unsafe for children who are learning how to move their bodies.
	Floors are covered by easy-to-clean carpet. Infants are barefoot whenever possible.	Floor coverings are dirty or hard and cold. Infants must wear shoes.

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Equipment	Toys are safe, washable, and too large for infants to swallow. They range fro very simple to more complex.	Toys are sharp, tiny, with chipping paint, or otherwise unsafe and not washable. Toys are too simple or too complex for the infants served.
	Toys provided are responsive to the child's actions: bells, busy cards, balls, vinyl-covered pillows to climb on, large beads that snap together, nesting bowls, small blocks, shape sorters, music boxes, squeeze toys that squeak.	Toys are battery-powered or wind up so the baby just watches. Toys lack a variety of texture, size, and shape.
	Mobiles are designed to be seen from the child's viewpoint. They are removed when children can reach for and grasp them.	Mobiles are out of infants' vision. They are positioned where children can reach them.
	Toys are scaled to a size that enables infants to grasp, chew, and manipulate them (clutch balls, rattles, spoons, teethers, rubber dolls).	Toys are too large to handle, or unsafe for children to chew on.
	Toys are available on open shelves so children can make their own selections.	Toys are dumped in a box or kept out of children's reach forcing them to depend on adult's selection.
	Low climbing structures ad steps are provided. Structures are well padded and safe for exploration.	No provisions are made for children to climb, or structures are only safe for older, more mobile children.
	Books are heavy cardboard with rounded edges. They have bright pictures of familiar objects.	Books are not available, or are made of paper that tears easily. Books do not contain objects familiar or interesting to children. Faded colors or intricate drawings are used.
Health, safety, and nutrition	Pictorial materials depict a variety of ages and ethnic groups in a positive way.	Pictures are limited to cartoon characters or stereotypes.
	Health and safety precautions are taken to limit the spread of infectious disease. Toys that are mouthed are replaced when a child has finished with them so they can be cleaned with a bleach solution.	Toys are scattered on the floor and cleaned occasionally, not at all, or improperly. Bottles sit on the floor. Spills are ignored.
	Written records are maintained for each child. Immunizations are current. Up-to-date emergency information is readily available.	Written records are incomplete or outdated.
	Staff are in good health and take precautions not to spread infection.	Because of limited sick leave, staff come to work even when they are ill.
	Children are always under adult supervision.	Children are left unattended.
	The environment is safe for children--electrical outlets are covered, no hazardous substances are within children's reach, no extension cords are exposed.	Children are frequently told "no" to hazards that should be removed. Rocking chairs are placed in crawling areas.

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Health, safety, and nutrition (continued)	• Children are dresses appropriately for the weather and type of play they engage in. • Adults wash their hands before and after each diaper change, before and after feeding each infant. • Adults are aware of the symptoms of common illness, environmental hazards such as lead poisoning, and food or other allergies. • Diaper changing areas are easily and routinely sanitized after each change. • Children are always held with their bodies at an angle when being fed from a bottle. • Children who can sit up eat in groups of one or two with a caregiver to ensure adult assistance as needed. Finger foods are encouraged. Only healthy foods are fed. Eating is considered a sociable, happy time.	• Infants' clothing is too confining, uncomfortable, or difficult to manage. Infants are over- or under-dresses. • Adults are too casual or inconsistent about handwashing. • Staff do not notice or ignore changes in children's normal behavior or do not now children well enough to detect unusual behavior. • Several children are changed on the same surface without sanitizing it for each child. • Bottles are propped up for children or children are left lying down with a bottle. • Large groups of children are fed in sequence or left to their own devices. Cookies and other sugary foods are used as treats. Children are not allowed to mess with their food. Conversation is limited.
Staff-parent interactions	• Parents are viewed as the child's primary source of affection and care. Staff support parents and work with them to help them to feel confident as parents. • Parents and staff talk daily to share pertinent information about the child. • Staff help parents anticipate the child's next areas of development and prepare them to support the child.	• Staff feeling competition with parents. They avoid controversial issues rather than resolving them with parents. • Staff rarely talk with parents except at planned conferences. • Staff fail to provide parents wit information or insights to help them do what is best for their child.
Staff qualifications	• Staff enjoy working with infants and are warmly responsive to their needs. Staff have had training specially related to infant development and caregiving. They know what skills and behaviors emerge during the first few months, and support children as they become increasingly competent and knowledgeable. Staff are competent in first aid.	• Staff view work with infants as a chore and as custodial in nature. Staff have little or no training specific to infant development. They have unrealistic expectations for this age group. They are unaware of what to look for that might signal problems in development.
Staffing	• The group size and ratio of adults to infants is limited to allow for one-to-one interaction, intimate knowledge of individual babies, and consistent caregiving. Babies need to relate to the same, very few people each day. A ratio of 1 adult no more than 3 infants is best.	• Group size and staff-child ratio are too large to permit individual attention and constant supervision. Staffing patterns require infants to relate to more than 2 different adults during the caregiving day.

Integrated Components of APPROPRIATE and INAPPROPRIATE Practice for *TODDLERS*

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Interactions among adults and children	• Adults engage in many one-to-one, face-to-face conversations with toddlers. Adults let toddlers initiate language, and wait for a response, even from children whose language is limited. Adults label or name objects, describe events, and reflect feelings to help children learn new words. Adults simplify their language for toddlers who are just beginning to talk (instead of "It's time to wash your hands and have snack," the adult says, "Let's wash hands. Snack time!") Then as children acquire their own words, adults expand on the toddler's language (for example, *Toddler*- "Mary sock." *Adult*-"Oh, that's Mary's missing sock and you found it.").	• Adults talk at toddlers and do not wait for a response. Adult voices dominate or adults do not speak to children because they think they are too young to respond. Adults either talk "baby talk" or use language that is too complex for toddlers to understand.
	• Adults are supportive of toddlers as they acquire skills. Adults watch to see what the child is trying to do and provide the necessary support to help the child accomplish the task, allowing children to do what they are capable of doing and assisting with task that are frustrating.	• Adults are impatient and intrusive. They expect too much or too little of toddlers. Because it is faster, adults do tasks for toddlers that children can do themselves. Or adults allow children to become frustrated by task they cannot do.
	• Adults respond quickly to toddlers' cries or calls for help, recognizing that toddlers have limited language with which to communicate their needs.	• Crying is ignored or responded to irregularly or at adults' convenience.
	• Adults respect children's developing preferences for familiar objects, foods, and people. Adults permit children to keep their own favorite objects and provide limited options from which children may choose what they prefer to eat or wear. Children's preferences are seen as a healthy indication of a developing self-concept.	• Adults prohibit favored objects like blankets or toys or arbitrarily take them away or expect toddlers to share them with other children. Children are not given choices and preferences are not encouraged. Children are all expected to do the same thing.
	• Adults respect toddler's desire to carry favorite objects around with them, to move objects like household items from one place to another, and to roam around or sit and parallel play with toys and objects.	• Adults restrict objects to certain locations and do not tolerate hoarding, collecting, or carrying.

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Interactions among adults and children (continued)	• Adults patiently redirect toddlers to help guide children toward controlling their own impulses and behavior. When children fight over the same toy, the adult provides another like it or removes the toy. If neither of these strategies is effective, the adult may gently remove the toddler and redirect the child's attention by initiating play in another area. Adults only punish children for overtly dangerous behavior.	• Adults ignore disputes leading to a chaotic atmosphere or punish infractions harshly, frightening and humiliating children.
	• Adults recognize that constantly testing limits and expressing opposition to adults ("NO!") is art of developing a healthy sense of self as a separate, autonomous individual. Adults only say "No" when the prohibition relates to children's safety. Adults give positively worded directions ("Bang on the floor") not just restrictions ("Don't bang on the table").	• Adults are constantly saying "No!" to toddlers or becoming involved in power struggles over issues that do not relate to the child's health or well-being. Adults punish children for asserting themselves or saying "No."
	• Children are praised for their accomplishments and helped to feel increasingly competent and in control of themselves.	• Toddlers are criticized for what they cannot do or for their clumsy struggle to master a skill. Or adults foster dependency; children are overprotected and made to feel inadequate.
	• Children and their parents greeted warmly and with enthusiasm each morning. The day begins with a great deal of adult-child contact. Adults help toddlers settle into the group by reading books or quietly playing with them.	• Children are received coldly and given no individual attention. Toddlers are expected to begin the day with free play and little adult supervision.
	• Adults model the type of interactions with others that they want children to develop. Adults recognize that most of the time when toddlers are aggressive, hurting or biting other children, it is because they lack skills to cope with frustrating situations such as wanting another child's toy. Adults model for toddlers the words to say ("Susan, I want the jack-in-the-box now") or redirect them to another activity.	• Adults are aggressive, shout, or exhibit a lack of coping behaviors under stress. Adult attempts to punish or control the aggressive toddler escalate the hostility.
Living and learning with toddlers (curriculum)	• Adults recognize that routine tasks of living like eating, toileting, and dressing are important opportunities to help children learn about their world and to regulate their own behavior.	• Routine times are chaotic because all children are expected to do the same thing at the same time.

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Living and learning with toddlers (curriculum) (*continued*)	• Adults play with toddlers reciprocally, modeling for toddlers how to play imaginatively with baby dolls and accessories. For example, adults and children "tea party" where the adult pretends to drink from a cup ad exclaims how good it tastes and the toddler often models the adult.	• Adults do not play with toddlers because they feel silly or bored.
	• Adults support toddlers' play so that toddlers stay interested in an object or activity for longer periods of time and their play becomes more complex, moving fro simple awareness and exploration of objects to more complicated play like pretending.	• Adults do not think that supporting children's play is important. They do not understand the value of play for learning or they feel silly playing with young children.
	• Toddlers' solitary and parallel play is respected. Adults provide several of the same popular toys for children to play with alone or near another child. Adults realize tat having three or four of the same sought-after toy is more helpful than having one each of many different toys.	• Adults do not understand the value of solitary and parallel play and try to force children to play together. Adults arbitrarily expect children to share. Popular toys are not provided in duplicate and fought over constantly while others toys are seldom used.
	• Adults prepare the environment to allow for predictability and repetition, as well as events that can be expected and anticipated.	• Adults lose patience with doing many of the same things repeatedly and get bored by toddlers' needs to repeat tasks until they master them or feel secure in a predictable environment.
	• Adults frequently read to toddlers, individually on laps or in groups of two or three. Adults sing with toddlers, do fingerplays, act out simple stories like "The Three Bears" with children participating actively, or tell stories using a flannelboard or magnetic board, and allow the children to manipulate and place figures on the boards.	• Adults impose "group time" on toddlers forcing a large group to listen or watch an activity without opportunity for children to participate.
	• Toddlers are given appropriate art media such as large crayons, watercolor markers, ad large paper. Adults expect toddlers to explore and manipulate art materials and do *not* expect them to produce a finished art product. Adults *never* use food for art because toddlers are developing self-regulatory skills and must learn to distinguish between food and other objects that are not to be eaten.	• Toddlers are "helped" by teachers to produce a product, follow the adultmade model, or color a coloring book or ditto sheet. Tactilely sensitive toddlers are required to fingerpaint or are given edible fingerpaint or playdough because they will probably put it in their mouths.

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Living and learning with toddlers (curriculum) (*continued*)	• Time schedules are flexible and smooth, dictated more by children's needs than by adults. There is a relatively predictable sequence to the day to help children feel secure.	• Activities are dictated by rigid adherence to time schedules or the lack of any time schedule makes the day unpredictable.
	• Children's schedules are respected with regard to eating and sleeping. Toddlers are provided snacks more frequently and in smaller portions than older children. For example, 2 morning snacks are offered at earlier hours than are usually provided for preschoolers. Liquids are provided frequently. Children's food preferences are respected.	• Schedules are rigid and based on adults' rather than children's needs. Food is used for rewards or withheld as punishment. Children are allowed to become fussy and cranky waiting for food that is served on a rigid schedule.
	• Diaper changing, toilet learning, eating, dressing, and other routines are viewed as vital learning experiences.	• Routines are dealt with superficially and indifferently.
	• Children learn to use the toilet through consistent, positive encouragement by adults. When toddlers reach an age where they feel confident and unafraid to sit a potty seat, adults invite them to use the potty, help them as needed, provide manageable clothing, and positively reinforce their behavior regardless of the outcome. Children are provided a toddler- appropriate potty seat and step-stool, if needed, in a well-lit, inviting, relatively private space. Children are taken to the toilet frequently and regularly in response to their own biological habits. Toddlers are never scolded or shamed about toileting or wet diapers/pants.	• Toilet learning is imposed on children to meet the adults' needs, whether children are ready or not. Children are made to sit on the potty for undue lengths of time and only reinforced contingent on urinating or defecating in the potty. Children are punished or shamed for toileting accidents.
	• Healthy, accepting attitudes about children's bodies and their functions are expressed.	• Children are made to feel their bodies are not to be admired, and that bodily functions are disgusting.
	• Children have daily opportunities for exploratory activity outdoors, such as water and sand play and easel painting. Waterplay is available daily, requiring that adults dry clothes or provide clothing changes. Children have opportunities for supervised play in sand. Adults recognize that sand is a soft and absorbing medium ideally suited for toddler exploration. Well-supervised sand play is used to teach children to self-regulate what they can and cannot eat.	• Adults do not offer water and sand play because they are messy and require supervision, using as an excuse that children will get wet or will eat sand. Children's natural enjoyment of water play is frustrated so they play in toilets or at sinks whenever they can.

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Living and learning with toddlers (curriculum) (*continued*)	• Routines are planned as learning experiences to help children become skilled and independent. Meals and snacks include finger food or utensils that are easier for toddlers to use such as bowls, spoons, and graduated versions of drinking objects from bottles to cups. Dressing and undressing are seen as learning activities and children's attempts to dress themselves and put on shoes are supported and positively encouraged.	• Adults foster children's dependence by doing routine tasks for them tat they could do for themselves. Children feel incompetent because the eating utensils are too difficult for them or clothes require adult assistance with tiny buttons or laces.
	• Food is ready before children are called to meals so they do not have to wait.	• Hungry toddlers become frustrated and cranky when they are set up to eat and then must wait to be served.
Environment	• The diapering/toileting, sleeping, feeding, and play areas are separate both for sanitation and to ensure quiet, restful areas.	• Areas are combined and very noisy and distracting.
	• The environment contains both soft (pillows, padded walls, carpeting) and hard (rocking chairs, mirrors) elements.	• The environment is dominated be hard surfaces because they are easier to keep clean.
	• The environment contains private spaces with room for no more than 2 children.	• The environment provides no private spaces.
	• Children have their own cribs or cots, bedding, feeding utensils, clothing, and other special comforting objects. Toddler's names are used to label every personal item.	• Children share sleeping quarters in shifts, or otherwise do not have their own special supplies. Favored objects are not permitted.
	• Children have many opportunities for active, large muscle play both indoors and outdoors. The environment includes ramps and steps that are the correct size for children to practice newly acquired skills. Toddlers' outdoor play space is separate from tat of older children. Outdoor play equipment for toddlers includes small climbing equipment that the can go around, in, and out of, and solitary play equipment requiring supervision such as swings and low slides.	• Toddler's indoor space is cramped and unsafe for children who are just learning how to move their bodies and need to run more than walk. Toddlers share outdoor space and unsafe equipment designed for older children.
	• The room is cheerful and decorated at the children's eye level with pictures of faces of people, friendly animals, and other familiar objects. Pictures of children and their families are encouraged.	• Areas are dingy and dark. Decorations are at adult eye levels or are too syrupy and cute. No evidence exists of personal involvement for families.

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Environment (Continued)	Sturdy picture books are provided. Pictures depict a variety of ages and ethnic groups in a positive way.	Books are not available because they get torn or soiled. Pictures are cartoons or other stereotypes.
	Toys are available on open shelves so children can make their own selections. Toys can be carried and moved about in the environment as children choose.	Toys are dumped in a box or kept away from childrens reach so they are at the mercy of the adult's selection. Adults attempt to restrict the use of toys to certain areas, like housekeeping or blocks.
	Climbing structures and steps are low, well-padded, and safe for exploration.	No provisions are made for children to climb, or structures are safe only for older, more mobile children.
Health, safety, and nutrition	Health and safety precautions are taken to limit the spread of infectious disease. Toys that are mouthed are replaced when a child has finished with them so they can be cleaned with a bleach solution.	Toys are scattered on the floor and cleaned occasionally, not at all, or improperly.
	Written records are maintained for each child. Immunizations are current. Up-to-date emergency information is readily available.	Written records are incomplete or outdated.
	Staff are in good health and take precautions not to spread infection.	Because of limited or no sick leave, staff come to work eve when they are ill.
	Children are always under adult supervision.	Children are left unattended.
	The environment is safe for children—electrical outlets are covered, no hazardous substances are within children's reach, no extension cords are exposed.	Children are frequently told "no" to hazards that should be removed.
	Children are dressed appropriately for the weather and type of play they engage in	Toddlers' clothing is too confining, uncomfortable, or difficult to manage.
	Adults wash their hands before and after each diaper change, before and after assisting children with toileting, and before handling food.	Adults are inconsistent to too casual about handwashing.
	Adults are aware of the symptoms of common illnesses, alert to changes in children's behavior that may signal illness or allergies.	Staff do not notice or ignore changes in children's behavior or do not know children well enough to detect changes in normal patterns of behavior.
	Diaper changing areas are easily and routinely sanitized after each change.	Several children are changed on the same surface.
Staff-parent interactions	Parents are viewed as the child's primary source of affection and care. Staff support parents and work with them to help them feel confident as parents.	Staff feel in competition with parents. They avoid controversial issues rather than resolving them with parents.

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Staff-parent interactions (continued)	• Parents and staff talk daily to share pertinent information about the child. There is an established system for keeping records of children's daily activity and health and reporting to parents.	• Staff rarely talk with parents except at planned conferences.
	• Staff help parents anticipate the child's next areas of development and prepare them to support the child.	• Staff fail to provide parents with information or insights to help them do what is best for their child.
Staff qualifications	• Staff enjoy working with toddlers, are warmly responsive to their needs, and demonstrate considerable patience in supporting children as they become increasingly competent and independent. Staff have training in child development and early education specific to the toddler age group. Staff are competent in first aid.	• Staff view work with toddlers as a chore and as custodial in nature. They push children to achieve and are impatient with their struggles, or they expect too little of toddlers. They are unaware of what to look for that might signal problems in development. Staff have no training in child development/early education or their training and experience are limited to working with older children.
Staffing	• The group size and ratio of adults to children is limited to allow for the intimate, interpersonal atmosphere, and high level of supervision toddlers require. Maximum group size is 12 with 1 adult for no more than 6 toddlers, preferably fewer. Staffing patterns limit the number of different adults toddlers relate to each day.	• Group size and staff-child ratio are too large to allow for individual attention and close supervision. Staff contain the chaos rather than respond to and support individual development. Staffing patterns require toddlers to relate to several different adults who do not know them well.

Developmentally Appropriate Practice in Programs for 3-Year-Olds

The 3 year-old is sometimes overlooked when periods of development are described in broad categories like "toddlers" or "preschoolers". But the fourth year of life is a distinct period of development with its own unique challenges and accomplishments. Teachers in programs serving 3-year-olds, as in all early childhood programs, must consider what is appropriate for this age group in general as well as what is specifically appropriate for the individual children in their care.

Three-year-olds are no longer toddlers but they will behave like toddlers at times; at other times their language ability and motor skills will deceptively mimic the 4-year-old. The key for the teacher of 3s is to maintain appropriate expectations; teachers should not expect too little of 3-year-olds, nor should they expect too much. To care for and educate a group of 3s, teachers need to fully understand the developmental continuum from toddlerhood through the preschool years. At 2 1/2, many children begin to display skills and behaviors most typical of 3-year-olds. Thus, children between 2 1/2 and 3 1/2 years of age are often similar developmentally; and some 3 1/2-year-olds share traits of 4s. The common practice of multiage grouping, putting children of a wide span together, further necessitates that teachers fully understand the continuum of development during the early years.

The following statement describes come developmentally appropriate and inappropriate practices specifically related to 3-year-olds. *This statement is not intended to describe a comprehensive program for 3s. It is intended to be used with the statement on appropriate practice for toddlers* (pages 40-46) *and the statement on appropriate practice for 4- and 5-year-olds* (pages 51-59).

Living and Learning With 3-year-olds: Interactions Among Adults and Children and Appropriate Curriculum

APPROPRIATE Practice	INAPPROPRIATE Practice
• Adults provide affection and support, comforting children when they cry and reassuring them when fearful. Adults plan experiences to alleviate children's fears.	• Adults are cold or distant ad do not express physical affection, comfort, or emotional bolstering. Adults assume children will get over fears.
• Adults support 3-year-olds' play and developing independence, helping when needed, but allowing them to do what they are capable of doing and what they want to do for themselves ("I can do it myself").	• Adults expect 3-year-olds to be independent and to entertain themselves for long periods of time; they are impatient, hurry children, and do tasks for children that they could do themselves.
• Adults recognize that, although 3-year-olds are usually more cooperative than toddlers and want to please adults, they may revert to toddler behavior (thumb-sucking, crying, hitting, baby talk) when they are feeling shy or upset, especially in a new situation. Adults know that 3-year-olds' interest in babies, and especially their own recent infancy, is an opportunity for children to learn about themselves and human development.	• Adults expect too much of 3-year-olds and ridicule them when they behave immaturely or play baby ("You're acting like a baby!").

APPROPRIATE Practice	INAPPROPRIATE Practice
Adults provide opportunities for 3-year-olds to demonstrate and practice their newly developed self-help skills and their desire to help adults with dressing and undressing, toileting, feeding themselves (including helping with pouring milk or setting the table), brushing teeth, washing hands, ad helping pick up toys. Adults are patient with occasional toileting accidents, spilled food, and unfinished jobs.	Adults perform routine tasks (like dressing and cleaning up) for children because it is faster and less messy. Adults punish or shame children for toileting accidents and do not allow children to play with their food. Adults insist that children pick up the toys every time.
Adults know that growth rates may slow down and appetites decrease at this age. Children are encouraged to eat "tastes" in small portions with the possibility of more servings if desired.	Adults serve children a large meal which they are expected to eat. Disciplinary pressures accompany demands for food consumption.
Adults guide 3-year-olds to take naps or do restful activities periodically throughout the day, recognizing that these younger children may exhaust themselves—especially when trying to keep up with older children in the group.	Naptime is either forced or not provided. Children are scolded for being cranky or tired as the day progresses.
Adults provide many opportunities for 3s to play by themselves, next to another child (parallel play), or with one or two other children. Adults recognize that 3-year-olds are not comfortable with much group participation. Adults read a story or play music with small groups and allow children to enter and leave the group at will.	Adults expect children to participate in whole group activities. They read a story to all the children at once, expecting them all to sit and listen quietly. They do not allow children to leave the large group activity.
Adults support children's beginning friendships, recognizing that such relationships ("my best friend") are short-lived and may consist of acting silly together or chasing for a few minutes. When conflicts arise, 3-year-old will often return to playing alone. Adults encourage children to take turns and share but do not always expect children to give up favored items.	Adults expect children will always want to play with their "Friends" and require that they do activities together of share toys. Adults pick out friends for children and keep pairs together over time.
Adults provide plenty of space and time indoors and outdoors for children to explore and exercise their large muscle skills like running, jumping, galloping, riding a tricycle, or catching a ball, with adults close by to offer assistance as needed.	Adults restrict children's physical activity ("No running!") or provide limited space and little equipment for large muscle outdoor activity. Adults limit large muscle activity to a short recess time.
Adults provided large amounts of uninterrupted time for children to persist at self-chosen tasks and activities and to practice and perfect their newly developed physical skills if they choose.	Adults become impatient with children who want to repeat a task or activity again and again, OR they force children to repeat tasks that adults have selected as learning activities whether the child is interested or not.

APPROPRIATE Practice	INAPPROPRIATE Practice
• Adults provide many materials and opportunities for children to develop fine motor skills such as puzzles, pegboards, beads to string, construction sets, and art materials (crayons, brushes, paints, markers, play dough, blunt scissors). Although children's scribbles are more controlled tan those of toddlers, and 3-year-olds will create designs with horizontal and vertical strokes, and will sometimes name their drawings and paintings, adults do not expect a representational product. Art is viewed as creative expression and exploration of materials.	• Adult expect children to demonstrate fine motor skills by cutting out figures or shapes, by coloring within the lines in coloring books or on ditto sheets, or following the teacher's directions and model to create identical art products. When children draw or paint pictures, teachers ask "What is it?" and lead children to believe that only a representational picture is valued.
• Adults provide plenty of materials and time children to explore and learn about the environment, to exercise their natural curiosity, and to experiment with cause and effect relationships. For example, they provide blocks (that children line up first and later may build into towers); more complex dramatic play props (for playing work and family roles and animals); sand and water wit tools for pouring , measuring, and scooping; many toys and tools to experiment with like knobs, latches, and any toy that opens, closes, and can be taken apart; and simple science activities like blowing bubbles, flying kites, or planting seeds.	• Adults may provide blocks and dramatic play areas but have definite ideas about how these areas could be use and restrict materials to be designated area of the room. Water play and sand play are not provided because they are too messy and difficult to supervise. Adults do not provide toys and tools to use in take-apart activities because they require too much time to clean up.
• Adults encourage children's developing language by speaking clearly and frequently to individual children and listening to their response. Adults respond quickly and appropriately to children's verbal initiatives. They recognize that talking may be more important than listening for 3-year-olds. Adults patiently answer children's questions ("Why?" "How come?") and recognize that 3-year-olds often ask questions they know the answers to in order to open a discussion or practice giving answers themselves. Adults know that children are rapidly acquiring language, experimenting with verbal sounds, and beginning to use language to solve problems and learn concepts.	• Adults attempt to maintain quiet in the classroom and punish children who talk too much. Adults speak to the whole group most of the time and only speak to individual children to admonish or discipline them. Adults ridicule children's asking of rhetorical questions by saying, "Oh, you know that."
• Adults provide many experiences and opportunities to extend children's language and musical abilities. Adults read books to one child or a small group; recite poems, nursery rhymes ad finger plays; encourage children to sing songs and listen to recordings; facilitate children's play of circle ad movement games like London Bridge, Farmer in the Dell, and Ring Around the Rosie; provide simple rhythm instruments; listen to stories that children tell or write stories that they dictate; and enjoy 3-year-olds' sense of humor.	• Adults limit language and music activities because children sometimes become too silly or loud, OR they include story time and music time only as a whole group activity and require children participate. Adults discipline children for using silly or nonsense language.

APPROPRIATE Practice	INAPPROPRIATE Practice
• Adults know that 3-year-olds do not usually understand or remember the rules. Guidance reasons that are specific to a real situation and that are demonstrated repeatedly are more likely to impress young children.	• Adults expect children to remember and abide by a list of classroom rules. Children are scolded and belittled for not remembering and applying a rule.
• Adults provide a safe, hazard-free environment and careful supervision. Adults recognize that 3-year-olds often overestimate their newly developed physical powers and will try activities that are unsafe or beyond their ability (especially in multiage groups where they may model 4- and 5-year-olds). Adults protect children's safety in these situations while also helping them deal with their frustration and maintain their self-confidence ("Joel can tie his shoe because he's 5; when you're 5, you'll probably know how to tie, too").	• Adults are careless about supervision especially when 3-year-olds are in a group of mostly 4- and 5-year-olds who are capable of ore self-monitoring and control of their own bodies.

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See references on pages 14-16, 32-33, and 61.

Integrated Components of APPROPRIATE and INAPPROPRIATE Practice for 4- AND 5-YEAR-OLD CHILDREN

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Curriculum goals	• Experiences are provided that meet children's needs and stimulate learning in all developmental areas--physical, social, emotional, and intellectual. • Each child is viewed as a unique person with an individual pattern ad timing of growth an development. The curriculum and adults' interaction are responsive to individual differences in ability and interests Different level of ability, development, and learning styles are expected, accepted, and used to design appropriate activities.	• Experiences are narrowly focused on the child's intellectual development without recognition that all area of a child's development are interrelated. • Children are evaluated only against a predetermined measure, such as a standardized group norm or adult standard of behavior. All are expected to perform the same tasks and achieve the same narrowly defined, easily measured skills.
Teaching strategies	• Interactions and activities are designed to develop children's self-esteem and positive feelings toward learning.	• Children's worth is measured by how well they conform to rigid expectations and perform on standardized tests.
	• Teachers prepare the environment for children to learn through active exploration and interaction with adults, other children, and materials.	• Teachers use highly structured, teacher-directed lessons almost exclusively.
	• Children select many of their own activities from among a variety of learning areas the teacher prepares, including dramatic play, blocks, science, math, games and puzzles, books, recordings, are, and music.	• The teacher directs all the activity deciding what children will do a when. The teacher does most of the activity for the children, such as cutting shapes, performing steps in an experiment.
	• Children are expected to be physically and mentally active. Children choose from among activities the teacher has set up or the children spontaneously initiate.	• Children are expected to sit down, watch, be quiet, and listen, or do paper-and-pencil tasks for inappropriately long periods of time. A major portion of time is spent passively sitting, listening, and waiting.
	• Children work individually or in small informal groups most of the time. • Children are provided concrete learning activities with materials and people relevant to their own life experiences.	• Large group, teacher-directed instruction is used most of the time. • Workbooks, ditto sheets, flashcards, and other similarly structured abstract materials dominate the curriculum.

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Teaching strategies (*continued*)	• Teachers move among groups and individuals to facilitate children's involvement with material s and activities by asking questions, offering suggestions, or adding more complex materials or ideas to a situation.	• Teachers dominate the environment by talking to the whole group most of the time and telling children what to do.
	• Teachers accept that there is often more than one right answer. Teachers recognize that children learn from self-directed problem solving and experimentation.	• Children are expected to respond correctly with one right answer. Rote memorization and drill are emphasized.
Guidance of social-emotional development	• Teachers facilitate the development of self-control in children by using positive guidance techniques such as modeling and encouraging expected behavior, redirecting children to a more acceptable activity, and setting clear limits. Teachers' expectations match and respect children's developing capabilities.	• Teachers spend a great deal of time enforcing rules punishing unacceptable behavior, demanding children sit and be quiet, or refereeing disagreements.
	• Children are provided many opportunities to develop social skills such as cooperating, helping, negotiating, and talking with the person involved to solve interpersonal problems. Teachers facilitate the development of these positive social skills at all times.	• Children work individually at desks or tables most of the time or listen to teacher directions in the total group. Teachers intervene to resolve disputes or enforce classroom rules and schedules.
Language development and literacy	• Children are provided many opportunities to see how reading and writing are useful before they are instructed in letter names, sounds, and word identification. Basic skills develop when they are meaningful to children. An abundance of these types of activities is provided to develop language and literacy through meaningful experience: listening to and reading stories and poems; taking field trips; dictating stories; seeing classroom charts and other print in use; participating in dramatic play and other experiences requiring communication; talking informally with other children and adults; and experimenting with writing by drawing, copying, and inventing their own spelling.	• Reading and writing instruction stresses isolated skill development such as recognizing single letters, reciting the alphabet song, coloring within predefined lines, or being instructed in correct formation of letters on a printed line.

Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Cognitive development	• Children develop understanding of concepts about themselves, others, and the world around them through observation, interacting with people and real objects, and seeking solutions to concrete problems. Learnings about math, science, social studies, health, and other content areas are all integrated through meaningful activities such as those when children build with blocks; measure sand, water, or ingredients for cooking; observe changes in the environment; work with wood and tools; sort objects for a purpose; explore animals, plants, water, wheels and gears; sing and listen to music form various cultures; and draw, paint, and work with clay. Routines are followed that help children keep themselves healthy and safe.	• Instruction stresses isolated skill development through memorization and rote, such as counting, circling an item on a worksheet, memorization facts, watching demonstration, drilling wit flash-cards, or looking at maps. Children's cognitive development is seen as fragmented in content areas such as math, science, or social studies, and times are set aside to concentrate on each area.
Physical development	• Children have daily opportunities to use large muscles, including running, jumping, and balancing. Outdoor activity is planned daily so children can develop large muscle skills, learn and outdoor environments, and express themselves freely and loudly. • Children have daily opportunities to use develop small muscles skills through play activities such as pegboards, puzzles, painting, cutting, and other similar activities.	• Opportunity for large muscle activity is limited. Outdoor time is limited because it is viewed as interfering with instructional time or, if provided, is viewed as recess (a way to get children to use up excess energy), rather than an integral part of children's learning environment. • Small motor activity is limited to writing with pencils, or coloring predrawn forms, or similar structured lessons.
Aesthetic development	• Children have daily opportunities for aesthetic expression and appreciation through art and music. Children experiment and enjoy various forms of music. A variety of art media are available for creative expressions, such as easel and finger painting and clay.	• Art and music are provided only when time permits. Art consists of coloring predrawn forms, copying an adult-made model of a product, or following other adult-prescribed directions.
Motivation	• Children's natural curiosity and desire to make sense of their world are used to motivate them to become involved in learning activities.	• Children are required to participate in all activities to obtain the teacher's approval, to obtain extrinsic rewards like stickers or privileges, or to avoid punishment.

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Component	APPROPRIATE Practice	INAPPROPRIATE Practice
Parent-teacher relations	• Teachers work in partnership with parents, communicating regularly to build mutual understanding and greater consistency for children.	• Teachers communicate with parents only about problems or conflicts. Parents view teachers as experts and feel isolated from their child's experiences.
Assessment of children	• Decisions that have a major impact on children (such as enrollment, retention, assignment to remedial classes) are based primarily on information obtained from observations by teachers and parents, not on the basis of a single test score. Development a assessment of children's progress and achievement is used to plan curriculum, identify children with special needs, communicate with parents, and evaluate the program's effectiveness.	• Psychometric tests are used as the sole criterion to prohibit entrance to the program or to recommend that children be retained or placed in remedial classrooms.
Program entry	• In public schools, there is a place for every child of legal entry age, regardless of the developmental level of the child. No public school program should deny access to children on the basis of results of screening or other arbitrary determinations of the child's lack of readiness. The educational system adjusts to the developmental needs and levels of the children it serves; children are not expected to adapt to an inappropriate system.	• Eligible-age children are denied entry to kindergarten or retained in kindergarten because they are judged not ready on the basis of inappropriate and inflexible expectations.
Teacher qualifications	• Teachers are qualified to work with 4- and 5-year-olds through college-level preparation in Early Childhood Education or Child development and supervised experience with this age group.	• Teachers with no specialized training or supervised experience working with 4- and 5-year-olds are viewed as qualified because they are state certified, regardless of the level of certification.
Staffing	• The group size and ratio of teachers to children is limited to enable individualized and age-appropriate programming. Four- and 5-year-olds are in groups of no more than 20 children with 2 adults.	• Because older children can function reasonably well in large groups, it is assumed that group size and number of adults can be the same for 4- and 5-year-olds as for elementary grades.

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2 MODULE

WHO ARE THE CHILDREN?

BASIC IDEAS ABOUT EARLY CHILDHOOD AND YOUNG CHILDREN DISABILITIES

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It is the early years which provide the foundation for life. During this exciting period, the buds of love, trust, curiosity, tenacity, drive, persistence, patience, and humor are first nurtured. During early childhood, the young child develops a sense of self, becomes aware of others, and begins to develop values and attitudes. It is a time crucial to development and one quite dependent on adults. Adults, therefore, must protect, nurture, and respect young children and their need to observe, question, move, explore, and practice. Very young children need adults who support them and interpret for them the things they see and feel. Adults must create safe environments where children are free to express feelings and ask questions.

Early childhood programs are settings where children can work closely with other children and with adults, to explore new ideas and confirm familiar ones. Here, the child can become aware of the things he/she can do that others can't and what others do that he/she finds difficult. In early childhood programs, young children begin to notice similarities and differences in size and shape, in settings and the rules that accompany each, between teachers and mothers and fathers and between one another. It is important that the adults in an early childhood setting understand that learning is taking place at all times.

In all outstanding classrooms, each child is taught by teachers who encourage and inspire while being fair and impartial. Children are very sensitive to attitudes. They learn how to treat one another from watching how adults treat children. The acceptance of differences needs to be a shared value in early childhood programs. Parents and early childhood program staff must now learn about working with, relating to, and including all people in the mainstream of society. They must think about how to do this in a respectful way that will encourage young children to have positive attitudes.

Increasingly, community programs are moving toward including children with disabilities. These programs have been encouraged to do so by parents asking that their children have the same opportunities to develop friendships and take advantage of neighborhood programs as children without disabilities. Parents are supported by public education laws mandating that young children with disabilities have opportunities to learn along side of children without disabilities.

It is helpful, perhaps, for those who teach to reflect on the skills they have already developed for working with young children in groups. Once managing a group of young children becomes second nature, or at least less overwhelming, addressing children individually within the group becomes the important skill to be mastered. One child is shy and must not be pushed, another always needs more of the materials than it is possible to provide, while a third needs an adult nearby to support his/her efforts to keep from hitting.

These same skills can be expanded to include children with additional needs a little less common than those already mentioned. For example, a bright, communicative child who has a physical disability, must use a wheel chair to get about the classroom. Initially inexperienced staff can't imagine a class which includes a child with these special needs. How will they move to the lunch room? What will happen when everyone goes onto the playground? How will they explain to the other children and their parents? Once accurate information has been provided, a relationship with the child and family developed, and weeks of the program have been experienced, apprehensions subside. "I can't imagine why I made such a fuss", is the retrospective remark so often heard.

Early childhood is a world rich in opportunities through individual experiences, and relationships with people. It is important that the adults focus on the goal of helping young children to develop as fully as possible so that they can experience life's pleasures and find life's rewards. Part of that goal is to teach young children to appreciate similarities and differences for no two people are alike.

CHILDREN WITH COGNITIVE IMPAIRMENTS

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Background Information:

The term mental retardation has been defined by the American Psychiatric Association (1980) as 1) Intellectual functioning that is more than two standard deviations below norm, 2) resulting from an injury, disease, or problem that existed before age 18 and 3) impaired ability adapt to the environment. Based on this definition, it is suggested that approximately 2.5% of the population has mental retardation. Causes of mental retardation may include newborn trauma, infectious disease, chromosomal abnormalities or unborn metabolic errors; however, 60% of the cases of mental retardation have an unclear etiology.

There is no cure for mental retardation although some researchers have attempted treatments such as megavitamin therapy, mineral supplements, special diets, medications and retraining other parts of the brain to increase ability. Even though a cure does not exist, intervention opportunities to maximize an individual's ability and potential is available.

Effect on Early Development:

Infants begin their development through involuntary or reflexive responses to the environment. Generally, children progress through a fairly predictable developmental sequence as a result of brain growth and interactive learning experiences. A young child typically develops in a head to toe progression with an integration of reflexive behavior toward a more purposeful or voluntary behavior scheme. Children with mental retardation, however, do not always follow this early developmental sequence or may require an extended amount of time to acquire these controlled behaviors. Children manifesting this slower developmental progression are often labeled as children with developmental delays. This atypical development which includes the areas of language, motor and socialization is often initially observed and reported by parents or other primary caretakers.

Impact on Integrated Settings:

The diagnosis of mental retardation falls into three categories: mild, moderate, and severe and profound retardation. A child with mild retardation usually learns more slowly than same-age peers. These children may develop language more slowly, have difficulty remembering information and directions as well as coordinating their eye-hand movements. Children with mild retardation may often learn many of the activities in an early childhood classroom but need more assistance and practices.

Young children with moderate retardation usually exhibit significant delays in all areas of development. These children are very delayed in talking,experience great difficulty in remembering information and directions. The early childhood environment must provide students with frequent opportunities for instruction and practice. Using less complex language and breaking tasks into small parts can also be helpful. These children benefit from interaction with same-age typically developing peers.

Preschoolers who have severe and profound retardation often need additional assistance with many daily activities. Often these children may require intervention from a specific discipline such as speech and language therapy as well as motor therapy. These services can be offered within the normalized context of the early childhood program with the daily child care providers implementing supplemental activities that facilitate the appropriate use of language and motor skills. Often children with sever/profound retardation also exhibit additional disabilities such as cerebral palsy or sensory impairments or a medical condition such as seizure disorder.

In developing activities or adapting the preschool curriculum of the young child with cognitive impairments, it will be important to draw on observations of the child's strengths and needs. Activities participation and outcomes should be relative to the child's abilities but challenging and motivating. It may be helpful to consult with the child's parents and specialist(s) in developing appropriate classroom activities. As with all children in the child care setting, continual observations and "evaluation" of the child's progress is important when developing new objectives.

CHILDREN WITH HEARING IMPAIRMENTS

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Young children with hearing impairments are more like other children without hearing impairments than they are like each other. While the hearing impairment is a common factor, the type of the hearing impairment, the age of the child when the impairment was detected, the age of the child when the hearing loss occurred and the severity of the impairment can make children with hearing impairment very different from each other. This paper will describe in general terms some of the characteristics of hearing impairment and the effects a hearing impairment can have on the development of young children.

A hearing loss can effect how loud a child hears a sound, and how distorted the sound is to the child. A child may hear sounds at a reduced volume, or he/she may not hear sounds at all. In addition, some children, usually with more severe hearing impairments, may hear a very distorted sound, making it difficult to understand or recognize.

Hearing impairments can be either sensorineural, conductive or a combination of both types of hearing loss. Both types of hearing impairment can occur during pregnancy or after birth. Sensorineural hearing losses occur when there is a problem in the inner ear or in the nerve that transmits the sound to the brain. These hearing losses can be caused by heredity, disease during pregnancy, viral infection (meningitis, encephalitis, mumps, measles, etc.), prolonged high fevers, physical damage to the head or ear, and extreme exposure to loud noise. Sensorineural hearing losses are usually more severe than conducted losses and are permanent. Medical treatments are not effective in reducing sensorineural hearing impairments, however, hearing aids are usually very helpful. Conductive losses occur when there is a problem in transmitting the sound to the inner ear due to temporary or permanent damage to the outer or middle ear. Conductive losses may be cause by severe of chronic ear infections, a ruptured ear drum, a deformity of the outer or middle ear, or a blockage in the ear from wax or a foreign object. Conductive losses can generally be reduced or cured with medical treatment. Some children may have a fluctuating conductive hearing loss that comes and goes with the onset of cold, ear infections, or allergies. These children will respond inconsistently to sound; responding one day but not on the next. While this type of hearing loss is difficult to detect, it is important to be aware of it because it can effect a young child's development.

During audiometric testing, it is possible to determine how loud a sound must be in order for the child to hear it. Hearing impairments are then categorized by how much volume is needed in order to hear the sound: Mild, (20-40 decibel loss, Moderate (40-70) decibel loss, Severe (70-90 decibel loss) or Profound (over a 90 decibel loss). The decibel is the unit used to measure the hearing loss. The term "deaf" is used to refer to those persons who have little use of their hearing for ordinary activities, usually those with profound hearing loss. "Hearing impaired" is used to refer to those persons who have some use of hearing for daily activities.

Hearing impairments has a primary effect on a young child's ability to learn to communicate. However, early communication difficulties can also effect a child's social, emotional and cognitive development. The degree of developmental difficulties that a child with hearing impairment experiences is effected by:

- The degree of hearing impairment;
- The age of onset of the hearing loss;
- The age when the hearing loss was detected;
- The age when the child started using a hearing aid and the consistency of hearing aid use; and
- The quality of early intervention services.

A child who has a mild hearing loss that was discovered early and who was provided with early intervention services will have a much better prognosis than a child with severe hearing loss that was diagnosed late and who has received little early intervention services.

Young children with hearing impairment have difficulties learning to develop both receptive and expressive communication. The hearing impairment can effect how well the child understand what is said to him/her. A child with a hearing impairment may need to learn to develop listening skills ranging from the identification of the presence of sound to the finer discrimination needed in speech. The child may also have difficulties developing speech communication skills. Some children with hearing impairments develop clear understandable speech, but others may have difficulties with language development, voice quality and rhythm, or articulation. Still other children with hearing impairments are taught to communicate using sign language. Sign language may be taught alone or may be used in conjunction with speech in an approach called Total Communication.

The difficulties a child with a hearing impairment has with communication development can also effect their social-emotional development. Children with hearing impairments may miss some of the auditory social cues that are important for learning to cooperate, share, and make friends. Their communication difficulties may also negatively effect their self-concept.

Children with hearing impairment have the same potential for cognitive development as their non-handicapped peers. However, since most cognitive development in young children is based on their abilities to use language, children with hearing impairments may be delayed. Helping to child with a hearing impairment to develop better communication skills will also help him/her develop better cognitive skills.

Some strategies for working with a child with hearing impairments include:

•Make sure that someone on the Team has expertise in the development of communication skills. A speech-language pathologist, audiologist, or teacher of the hearing impaired may play this role. Learn strategies to enhance communication abilities from the communication specialist.

•Understand how the child's hearing aid operates and how it amplifies sound. Remember that a hearing aid amplifies all sounds in an environment, not just the sounds that are important. Learn to check the hearing aid daily to see if it is working properly.

•If the environment is particularly noisy, use carpets, heavy curtains, or thick materials on the walls and floors to cut down on noise. Try to avoid placing noisy, distracting activities next to quieter one.

•Use visual material to enhance activities that rely heavily on listening skills. A few simple pictures can be used to enhance a story or music activity.

•Since children with hearing impairment rely on their vision, make good use of the lightning in the room. Watch out for glare and shadows. Arrange seating for activities with the teacher facing the light source and with the children facing away from it.

CHILDREN WITH MULTIPLE IMPAIRMENTS

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Most young children with impairments have only one area of disability. However, some children have more multiple needs. Multiple impairments can occur with any combination of physical, communicative, cognitive or sensory disabilities. Each young child with multiple impairments is different from other children with multiple impairments. However, young children with multiple impairments are more like children without impairments than they are different.

The combination of multiple impairments can effect the development of a young child much more than the effect of each single disability. The effect of multiple impairments is multiplicative rather than additive. The development of a young child with multiple impairments will differ depending on the type and severity of the impairments. It is important to look holistically at the strengths and needs of each individual child and to assess the potential for developmental differences.

Because of the wide range of strengths and needs of young children with multiple impairments, it is important to use a team approach. Using a team approach, the expertise of a wide number of personnel can be utilized to plan for the integration of the child. The team approach also involves collaboration and cross-training so that all team members can provide and plan for all the child's needs.

It is also important for the young child with multiple impairments to practice skills where they will need to use them. Young children with multiple impairments need assistance in developing their social, emotional, communicative, cognitive, and motoric abilities through normal, age-appropriate activities. No special activities are necessary. The role of the team is, therefore, to adapt everyday activities so that each child with multiple impairments can participate and learn.

2 MODULE

WHO ARE THE CHILDREN?

CHILDREN WHO HAVE PHYSICAL AND HEALTH IMPAIRMENTS

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Background Information

Children with physical impairments, as a group, constitute a "low-incidence" category. This group is also a very diverse grouping of children with a variety of motor, intellectual, sensory and social abilities. Physical impairments often effect a child's mobility and manual skills. This disability may result from bone or muscle impairments (musculoskeletal impairments) or damage or dysfunction of the brain or nervous system which specifically impairs voluntary control of muscle groups (neuromotor impairments). Physical disabilities are often classified on the basis of severity with labels such as mild, moderate or severe. These labels may provide a categorization for the motor impairment or the individual's overall impairment relative to functional or life skill development. Children with an orthopedic disability may experience special learning needs resulting from intellectual impairments or associated with "secondary impairments "affecting communication, perceptual processes or social-emotional development.

Orthopedic impairments are determined via a medical diagnosis which frequently emphasizes the child's limitations and differences relative to normal motor development. One of the most common diagnoses is cerebral palsy, a nonprogressive, neuromotor impairment. Cerebral palsy may result from a brain injury experienced during prenatal, perinatal or postnatal periods of development. The resulting motor disability depends on the location and extent of the brain lesion. Individuals with cerebral palsy may experience very mild motor involvement while others with this diagnosis may have multiple impairments. Cerebral palsy may also effect only parts of the body (Inge, 1987):

Classification	Limb Involvement
Monoplegia	One limb is involved (very rare)
Tripelgia	Three limbs are involved, usually one arm and both legs
Hemiplegia	One arm and one leg involved same side of the body
Paraplegia	Only the legs are involved
Diplegia	All limbs involved but legs are more involved
Quadripelgia	Major involvement throughout the body (all limbs)

Spina bifida (myelodysplasia) is another common physical impairment resulting from spinal cord damage (open spine at birth). This impairment may result in significant impaired sensation and movement of the lower extremities. Individuals with spina bifida can be "shunted" which provides for the drainage of cerebrospinal fluid from the brain. Individuals with spina bifida also practice Clean Intermittent Catherization (CIC) to empty the bladder.

Additional conditions resulting in physical disabilities include; arthrogryposis, juvenile rheumatoid arthritis, osteogenesis imperfecta, Legg-Calve-Perthes disease, achondroplastic dwarfism amd limb deficiency (phocomelia).

In addition to orthopedic disabilities, chronic health problems and diseases often require young children to receive additional assistance Several common "other health impairments" include: congenital or acquired heart conditions, cancer, hemophilia, chronic respiratory disease, allergies, asthma and sickle cell anemia.

Effects on Early Development

Orthopedic and other serious medical health impairments influence a young child's early development. Safford (1989) reports from Peterson (1987) that negative effects may include:

1. Social isolation and disruption in normal life experiences that promote early learning.
2. Physical limitations and reduction in energy level.
3. Potential disruption in interpersonal relations.
4. Effects upon parent's child rearing practices.
5. Alterations in a child's level of dependence/independence.
6. Side effects of medications.
7. Potential emotional effects of illness.

The pervasiveness of a physical impairment may also effect the child's communication skills thus the child may expereince extreme difficulty in communicating wants and needs.

Orthopedic disabilities that interfer with the child's mobility lessens the opportunities for the child to interact with the environmment. This may result in the lack of concept development involving causality, physical attributes and self. In addition, due to the frequent difficulty in achieving some control over the environment, the child may develop a limited sense of personal competence.

Implications for Integrated Programming

Campbell (1989) in Gaylord-Ross (1989) reports that it is important for "teachers of students with orthopedic handicaps to have knowledge about the origin(s) of the orthopedic problem, its impact on school performance, and any associated side-effects that may occur". Safford (1989) indicates that to actively include the child with orthopedic impairments in an integrated enviornment, the following suggestions should be considered:

1. Desks or tables and chairs and all working areas in the room should be arranged to provide ample room to accommodate tha child's equipment used for mobility.
2. Working materials should be accessible for one-handed use if the child needs to stand up for any acitivity.
3. Activities involving movement should allow the child to be involved as much as possible without accentuating his or her inability to move well.
4. Make the child with a disability inconspicuous.
5. Working materials should be accessible to the child at appropriate body level.
6. All children, including the child with a disability, need to be aware of safety rules.
7. Materials in the classroom can be organized according to their use within distinct areas, to reduce the requirement for unnecessary movement.

It is important to remember that children with other health impairments have often experienced lengthy hospital visits, spent more time at home and often require restricted activity. The early childhood care givers most take the responsibility of providing the child with the necessary guidelines relative to these situations.

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CHILDREN WHO HAVE SOCIAL AND EMOTIONAL DISABILITIES

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Young children who have emotional or social disabilities show unusual behaviors for long periods of time. However, children who are not emotionally disturbed may show these same, unusual behaviors from time to time. With non-disturbed children, these behaviors are almost always short-lived and caused by a situation you can identify. The unusual behaviors may be described as: withdrawing, anxious, and aggressive. In cases where these behaviors persist, these children may be described as experiencing an abrupt break, slowing down, or postponement in developing and maintaining meaningful relationships with other persons, and/or in developing a positive and accurate sense of self. Such children may have difficulty in:

- Developing the capacity to give and take in relationships;
- Identifying and appropriately expressing feelings;
- Learning skills and gaining self-confidence;
- Asking for and accepting help.

The very serious emotional disorders of childhood such as childhood schizophrenia and autism typically have clusters of symptoms such as:

- Problems in the way the child perceives the world;
- Problems in the sequence and rate at which the child achieves certain developmental milestones;
- Problems in speech and language development;
- Problems in forming relationships with other people;
- Problems in the way the child uses his or her body.

There are a number of general guidelines which a teacher should consider when working with a child with emotional disturbance in an integrated setting. The issue of positive self-concept is important for all children and especially for the child who is disturbed. Teachers need to plan activities to maximize inclusion and success, modeling a positive and caring approach. Keep activities simple and directions clear. Where necessary, keep the activity short to maximize the chances for success. Give children clear warning of impending transition. Help them to think about readying for the transition, walk with them or assign a partner to assist.

It is important to set clear limits for all young children and especially important for the child with emotional disturbance. Whatever behavioral and safety limits you set, be consistent in enforcing and modeling them. Ask yourself these question before setting a behavioral limit:

- How does it affect the other children?
- Does the child have control over the behavior?

- Is a change justified?

- Can you think of a substitute behavior?

Physical contact may be used to ensure the safety of the child and of those around him or her and to provide support, guidance, and encouragement. Children with emotional disturbances often benefit from being physically "moved through" an activity initially and benefit from the expressed affection that a hug can provide. It also may be necessary to hold a child when he/she is out-of-control and threatening to hurt himself and others.

While the behaviors of a child with emotional disturbance may be challenging to children and adults alike, good planning and positive approaches in an integrated setting can lead to substantial gains.

Lasher, M.G., Mattick, I., Perkins, F.J. (1978) Mainstreaming Preschoolers: Children with Emotional Disturbance. Washington, DC: U.S. Department of Health, Education and Welfare.

2 MODULE

WHO ARE THE CHILDREN?

CHILDREN WHO HAVE SPEECH AND LANGUAGE IMPAIRMENTS

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Young children having a serious speech or language problem that will continue to affect the way a child feels about him- or herself, learns in preschool, or gets along with others is considered an impairment.. Receptive and expressive language impairments are referred to as language impairments while stuttering, voice disorder, and articulation disorders are referred to as speech impairments.

Children with a receptive language disorder have difficulty in understanding spoken language. These children also have a difficult time learning to talk and will therefore have expressive problems also. Some children may only have expressive problems in that they appear to comprehend the spoken word but cannot readily produce language. They may use fewer words than other children their age or may not have learned the grammatical rules that their peers have mastered.

Speech impairments include stuttering or disfluency, chronic voice disorders, and articulation problems. A stuttering child may prolong or repeat sounds, syllables or sometimes whole words. The child's speech may also be interrupted by pauses during which the child is obviously trying to say something. Unusual behaviors such as eye blinks, tremors, or foot stamping may also take place as the child tries to force the words out. Most young children will experience some degree of disfluency and this is normal. It is when the behaviors described above continue in a frequent manner that an impairment is being experienced by the child.

Children with chronic voice disorders sound unusual most of the time. Their voice may be very loud or extremely quiet, hoarse, raspy, or strained. It may be extremely nasal sounding or may sound as though the child has a cold or sinus infection all the time.

Children with articulation disorders produce speech sounds which are very different from their peers. Sounds may be left out or distorted, extra sounds may be added or some sounds may be substituted for others. A child with a serious articulation problem produces sounds so poorly that the speech is unintelligible. This means that the child cannot usually be understood by most people in most situations, even by family members.

Speech and language problems may result from other disabling conditions such as hearing impairment, cleft palate, mental retardation and emotional disturbance. This association will be discussed in the sections concerning those disabilities.

In working with children who are speech and/or language impaired it is important to gain a good working knowledge of their capabilities. Appropriate expectations are important. Being a good listener is also important. Adults need to listen carefully to what is being said and praise the child for trying to talk. Parents can be of great help in trying to understand a child's speech. Pass on your knowledge and translate for other children where necessary.

Many children with language and speech problems do not initiate communication. It is important that you encourage their speech by:

- Enjoying verbally what children are engaged in;
    - Encouraging their bringing special things from home and providing the opportunity to talk about them with the group when they are ready;
    - Encouraging and listening as the children talk about how they feel;
    - Planning/scheduling many activities to provide many subjects for conversation;
    - Teaching the children to give important information (name, address, etc.)
    - Teaching a short rhyme or song which can be performed for others;
    - Including concepts which are familiar to the children;
    - Asking open-ended rather than yes-no questions.
    - Modeling sentences and words on a regular basis and linking them to meaningful objects, situations, and actions.
    - Expanding the child's speech by using descriptive new words and grammatical structures.

While the above apply to all children and are especially useful for children who have language impairments and are in integrated settings, there are some specific techniques that are useful with certain of the speech disorders.

Children with articulation problems are often not able to hear the difference between sounds. They often need assistance in learning how to listen. Some ways to help a child improve their auditory discrimination skills are to:

- Help the child learn to recognize the source of a sound;
- Help the child learn to recognize when two sounds are the same or different;
- Help the child to identify similar sounds;
- With the guidance of the speech therapist, begin working on the similarities and differences between speech sounds; and
- Help the child learn to hear the difference between the way he or she says a certain sound in a word and the way others produce the sound.

The disfluent or stuttering child can be positively impacted by adult behavior. Modeling relaxed and calm speech is important as is giving the child opportunities to speak without interruption or pressure. Children who stutter can speak fluently in some situations better than others . Try to discover these situations and help the child have fluent speech experiences every day. Avoid emotional reactions to stuttering and treat the situation matter-of-factly.

Liebergott, J., Favors, A. (1978) Mainstreaming Preschoolers: Children with Speech and Language Impairments. Washington, DC: U.S. Department of Health, Education, and Welfare.

CHILDREN WITH VISION IMPAIRMENTS

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Young children with visual impairments have a range of skills and abilities just like children without any visual handicaps. In fact, they are more like than not like children without handicapping conditions. However, it is important to understand the different types of visual handicaps and the effect they can have on the development of a young child.

A young child's vision can be effected in a variety of different ways, including acuity problems, field losses, and difficulties with muscle imbalance. Visual acuity refers to how well a person can see objects that are close and far away. Nearsightedness (myopia) or farsightedness (hyperopia) are common acuity problems. Acuity measures are commonly shown as a fraction, such as 20/70. A person with an acuity measure of 20/70 can see at 20 feet what a person with normal vision can see at 70 feet. Children with visual impairments may also have field losses. With this type of impairment, the child may have difficulty seeing in particular places, for example at the periphery or sides, or centrally. With tunnel vision, a type of field loss, peripheral vision is poor, with the best vision being present in the center of the visual field. Muscle imbalances, such as strabismus, can also cause vision difficulties. Both eyes need work together in order to focus clearly on objects. All types of visual impairments may occur in combination or alone. Vision losses may also occur before or after birth.

Children are considered "partially sighted" if their corrected vision in the best is between 20/70 and 20/200 or if corrected vision is better than 20/70 but with a reduced field of vision. Children are considered "blind" if their vision is 20/200 or if their vision is better than 20/200 but with a significantly reduced field of vision. A child may also be considered functionally blind if he/she relies on hearing and touch as the primary means of learning. It is important to understand that many children who are considered blind have some residual or remaining vision. Some children who are blind may be able to recognize large objects, while others may have some perception of light and dark. Very few children who are blind have no residual vision.

Children with visual impairments are often limited in how they learn about their environment. Because of the visual impairments, these children may only see a small portion of the environment or may be limited to exploring the parts of the environment that are within reach. Children with vision impairments may also be limited in what they can learn through imitation. These difficulties may effect how they develop motor, cognitive and communication skills.

Motor delays are not unusual for children with visual impairments. Often these delays are due to the lack of visual interest to reach out for toys, to sit up, or to walk toward an object. Motor delays may also be due to difficulty in visual imitation. Many gross motor skills are learned through imitation, so children with visual impairments may be delayed. Cognitive abilities may also be delayed because of the lack of opportunity to explore the environment and difficulties in imitating.

Children with visual impairments rely heavily on their hearing to understand their environment. They are often very verbal and imitative of auditory information. However, children with visual impairments may use words and phrases they do not clearly understand. Children with visual impairments may also miss many of the nonverbal facial and body cues that are available to other children.

2 Summary Papers

Some strategies for working with children who have visual impairments include:

- Make sure that someone on the Team has expertise in vision development and impairments. A teacher of the visually impaired or a special educator who has expertise in visual impairments may play their role. It is important to involve the ophthalmologist of optometrist on the Team.

    - Allow children with visual impairments to use all their senses to explore their environment. Use concrete experiences that allow children to smell, hear, touch and taste.

    - Encourage children to use as much of their residual vision as possible. The idea that "If you use it, you will lose it" is a myth.

    - Vision may change from day to day depending on factors such as lighting or fatigue. Be aware that it may change and that you may see inconsistent behavior as a result.

    - Make sure that materials are within reach and are appropriately marked (tactual cues or bright fluorescent colors) for a child with visual impairments. For example, mark a chair with a piece of carpet for the child with a visual impairment.

    - Arrange the physical environment so that the child may not clearly see all obstacles. Keep clear aisles, keep doors completely open or shut and push chairs under tables when not in use.

    - Some children with visual impairments need extra light, others are sensitive to light. Adjust the lightning in the room as necessary.

3 MODULE

WHO ARE THE ADULTS?

3 MODULE

WHO ARE THE ADULTS?

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- Parents on the Team
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3 MODULE

WHO ARE THE ADULTS?

I. MODULE OVERVIEW

LENGTH OF TRAINING

This module is designed to be completed in one, 3 1/2 hour session including approximately 30 minutes for breaks. Breaks may be inserted in the training as neede. It is recommended that the fifth session, Module 4, be conducted 2-7 days following the completion of Module 3. This time frame allows participants an opportunity to complete the Field Exercises while keeping the information current.

A. Purpose and Goals:

Purpose: To provide information on options for integrated programs, and to identify the roles, responsibilities and expertise of the adult team members including parents, early childhood educators, special educators, and other support service staff.

Goal 1: To identify and discuss current options for providing integrated settings for young children with disabilities and their families.

Goal 2: To identify and discuss the changes needed in roles, responsibilities, expertise and attitudes of adult team members in order to implement quality integrated programs.

Goal 3: To identify and discuss potential strategies for working as a team to integrate a young child with disabilities into a regular early childhood setting.

B. Trainer and Participant Expectations

The trainer should present the following expectations to participants. The expectations should be used as a guide by trainers to insure that the important material is covered during the training session.

1. The trainer will provide participants with information related to the current options used in Ohio to integrate young children with disabilities into early childhood settings.

2. The trainer will provide participants with information defining the team members' future roles, responsibilities, and expertise that will be necessary in order to facilitate the integration of young children with disabilities in early childhood settings.

3. The trainer will provide participants with information designed to discuss the benefits of the team process and strategies to develop teaming skills.

C. Additional Resources for the Trainer

Brown, D., Wyne, M.D., Blackburn, J.E., & Powell, W.C. (1979). *Consultation: Strategy for improving education.* Boston: Allyn & Bacon.

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Johnson, L.J., Pugach, M.C., & Hammitte, D.J. (1988). Barriers to effective special education consultation. *Remedial and Special Education,* 9(6), 41-47.

Ohio Department of Education, Division of Early Childhood Education. (Draft, 1991). Program Planning in Early Childhood Special Education. *Rules implementation monograph series for rules for the education of preschool children with disabilities served by public schools and county boards of mental retardation and developmental disabilities,* (Monograph No. 2). Columbus, OH: Author.

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Ohio Department of Education, Division of Special Education. (1982). *Rules for the education of handicapped children.* Columbus, OH: Author.

West, J.F. (Ed.) (1988). *School consultation: Interdisciplinary perspectives on theory, research, training, and practice.* Austin, TX: Research and Training Project on School Consultation.

NOTES

II. SUMMARY TRAINING OUTLINE

The summary training outline is provided to trainers as an organizational tool. It describes the basic outline of the content, appropriate places for training activities, and the presentation of audiovisual materials. A space has also been provided for making notes about materials, equipment and other training needs.

Key:

⛹⛹ = Activity

📽 = Overhead

LENGTH OF ACTIVITY

10 *minutes*

Opening Discussion

- Review of Module Outline, Purpose, Goals, Expectations, and Themes
- Review Field Exercises
- Changes in Roles and Responsibilities
- Changes in Skills and Knowledge

📽 #1 - #6

⛹⛹ #1

NOTES

40
minutes

Current Guidelines for Services to Young Children 0 - 8 Years

#7 - #11

- Trends in Providing Services to Young Children & Their Families
- Services to Infants and Toddlers in Ohio
- Preschool Regulations for Young Children 3 - 5 Years in Ohio
- Regulations for Children 6-8 Years in Ohio

NOTES

20
minutes

Models of Service Delivery

#12

- Itinerant Services in an Integrated Setting
- Classroom Services in an Integrated Setting
- Enrollment of Nonhandicapped Peers
- Early Childhood Centers

#2

NOTES

40
minutes

Role Changes in Integrated Settings

#13 - #14

- Changes in Roles and Responsibilities
- Changes in Skills and Knowledge
- Changes in Attitudes

#3 or **#4**

NOTES

50 *minutes*

Working as a Collaborative Team #1 - #17

- Definition
- The Collaborative Team Process

#5

NOTES

30 *minutes*

Closing Discussion #6

- Journal
- Review Expectations & Themes
- Review of Future Sessions
- Review Field Exercises
- Collect completed Workshop Evaluations

#1 - #6

#18

NOTES

III. MODELS OF PROVIDING INTEGRATED OPTIONS

#7

KEY IDEA: The current guidelines through the Departments of Health and Education for services to children between the ages of 0-8 years in Ohio allow for a variety of integrated options for placement and delivery of services. This section provides some background and discussion of the types of service delivery currently within the regulations.

NOTE: Trainers utilizing these materials in other states should substitute the relevant guidelines from their particular state.

A. Current Guidelines for Services to Young Children 0-8 Years

1. Trends in Providing Services to Young Children and Their Families

#8

In December 1988, The Great Lakes Area Regional Resource Center sponsored the *Early Childhood Planner's Conference on Integration and the Least Restrictive Environment for Young Children.* The conference was attended by representatives from state agencies responsible for early childhood services in a seven state area. The goal of the conference was to provide early childhood planners with an opportunity to discuss issues related to the provision of least restrictive environments for young children with disabilities. Participants met in state teams and developed seven recommendations about services for young children with disabilities. Their recommendations provide a format for thinking about services to young children with disabilities and their families. The recommendations were:

☆ A more appropriate concept for young children is the "Most Supportive" rather than the "Least Restrictive" environment.

☆ Placement decisions should be based on the question, "Where would this child be if he/she were not handicapped?".

☆ Parallel policies on the issue "Least Restrictive Environment" should be developed for the 0-2 and 3-5 population.

☆ "Regular" and "Special Early Childhood" teacher certification should be made either identical or reciprocal.

☆ Policy and regulatory barriers to the use of private placements should be amended.

☆ For the young child, it is important to consider the integration of the child into the family, the family into the community and, finally, the child into a program.

☆ The public's awareness regarding these issues must be raised.

2. Services to Infants and Toddlers 0-2 in Ohio

In Ohio, the lead agency for the provision of services to infants and toddlers (0-2 years) is the Department of Health. Legislation considered in the Ohio Legislature for early intervention services to infants and toddlers with disabilities and their families includes the following definition of Least Restrictive Environment:

#9

> *"Least Restrictive Environment" means an environment in which an infant or toddler receives early intervention services with other children who are not infants and toddlers at risk, that is used for an infant or toddler only when the nature and severity of the disabling condition of the infant or toddler prevents satisfactorily achieving the goals of the early intervention service for the infant or toddler in normal environmental settings, and is the environment in which the infant or toddler should receive early intervention services if he were not an infant or toddler at risk. (Section 3714.01, O)*

Under the proposed legislation, it will be the job of the local collaborative group to insure that:

> *Early intervention services are provided in a manner that is sensitive to the needs unique to the culture of the recipients and, to the extent possible, in the home, a day-care center, or any type of setting in which infants and toddlers receiving early intervention services are not isolated from activities in which children without handicaps participate. (Section 3714.11, E) In addition, the Ohio Department of Health is currently developing strategies related to the issues of child find, assessment, transition services, public awareness, interagency agreements, etc.*

#10

3. Preschool Regulations for Young Children 3-5 years in Ohio

As of July 1, 1991, school districts in Ohio will be responsible for implementing programs for children 3-5 years of age with disabilities. The Department of Education's *Rules for the Education of Preschool Children with Disabilities Served by Public Schools and County Boards of Mental Retardation and Developmental Disabilities* include the following alternative service delivery options.

> *(1) Itinerant services which may be delivered in the home environment or to a child attending a preschool/kindergarten program administered by a public school or a child attending a community-based preschool/kindergarten or child-care program that meets the requirements of Chapter 5104 of the revised code and where a qualified preschool staff member is assigned to the child; and*
>
> *(2) Special class located in an integrated or separate facility. (Chapter 3301-31, Section 03, C)*

The proposed rules also allow for the integration of a number of nonhandicapped peers into a segregated classroom. Chapter 3301-31, Section 03, J states that

> *Up to six age-eligible typically developing children may be enrolled in a special class for the purpose of establishing an integrated class setting. In such cases, class size shall not exceed twelve children.*

#11

4. Regulations for Children 6-8 years in Ohio

In Ohio, once a child reaches the age of 6, the child's program is no longer governed by the preschool rules and regulations. Instead, the regulations for all school age children, *Rules for the Education of Handicapped Children*, take effect. The school age rules allow for a continuum of service delivery options. Examples of the types of services available include: supplemental services teacher; individual/small group instruction; and, special class or learning centers. The supplemental services teacher has a role that is similar to the preschool itinerant teacher in that services are provided in the place where the child would be if he/she was not handicapped. Therefore, the supplemental services teacher provides aides and services that will allow the student to receive an appropriate education in a regular classroom. Individual or small group instruction may also be provided to students with disabilities. This service is designed to provide additional instruction to students whose primary placement is in a regular class. The final integrated option allowed by the school age regulations is the use of a special class or learning center on a full or part-time basis. Although this option does not permit full inclusion, some opportunities for interactions with nonhandicapped peers may be available. If special classes are within age-appropriate public school buildings, or if the student is enrolled in a special class on a part-time basis only, there may be some opportunities to develop integrated programming.

All special and general education roles in Ohio are currently open for revision. It is expected that the new rules will be in place.

#12

B. Models of Service Delivery

1. Itinerant Services in an Integrated Setting

One of the options described in the rules is to provide itinerant special education services to the child with disabilities in the home, public school preschool setting, or community preschool or child care setting. One advantage to this service delivery option is that the special education teacher and related services staff provide services to the child and family in the setting where the child would be if he or she did not have disabilities. Another advantage is that it allows for more normal proportions of children with disabilities to children without disabilities in the preschool setting.

In Ohio, the special education teacher, if serving only in an itinerant capacity would serve 10-20 preschool children with disabilities. If the special education teacher serves both in a special class and provides itinerant services, the number of children served can range from 12-16. Related service personnel may also serve in this capacity.

2. Classroom Services in an Integrated Setting

A second service delivery option described in the Ohio rules is to have a class for young children with disabilities located in an integrated setting. For example, a public school preschool classroom might be located in a neighborhood child care facility. This methodology does not guarantee that integration will occur. Therefore, the special education staff and early childhood education staff must work together to facilitate opportunities for children to interact.

One way to increase integration is to place children with disabilities into different classes in the facility rather than in just one room. To maintain the children with disabilities in each of the classrooms, support is provided by the special educator and related services staff. In some instances, the early childhood educator and the special educator have taught as a team in a classroom of children with and without disabilities. The proposed rules state that a special education teacher with a special class may provide services to six to eight children with disabilities.

3. Enrollment of Nonhandicapped Peers

Integrated options for preschool services can also occur in a setting that was primarily developed for children with disabilities. According to the rules, typically developing preschool children can be enrolled into a classroom of children with disabilities. This is also referred to as "reverse mainstreaming." The Ohio rules indicate that no more than 50% of the classroom may be for children without disabilities.

4. Early Childhood Centers

#2

Some of Ohio's counties have taken advantage of capitol building and renovation funds available through the Ohio Department of Mental Retardation and Developmental Disabilities and other community funding sources to develop Early Childhood Centers. These centers contain a variety of programs and services for young children with and without disabilities. For example, an Early Childhood Center might provide space for a Head Start program, a private child care facility, a public school preschool program, the county nurse, and the WIC program office. Integrated options for young children with disabilities and their families are available at the Early Childhood Center through itinerant services, team-teaching, reverse mainstreaming, etc.

IV. ROLE CHANGES IN INTEGRATED SETTINGS

#13

***KEY IDEA*:** Providing services to young children with disabilities in integrated settings may mean a variety of changes for families, early childhood educators, special educators, and other professionals. Changes may need to occur in the roles, responsibilities, skills, knowledge and attitudes of all participants in the integration process. This section describes the changes that may be necessary and some potential strategies to assist in the transition process.

#14

A. Changes in Roles and Responsibilities

Most adults in the field of education were taught how to be effective in working with children. However, integrated service delivery options may necessitate that educators work very closely with other adults. Very few educators were trained to work with other adults; this may cause some difficulties for adults who are trying to work together. Providing integrated options for young children will require both early childhood educators and special educators to be flexible and willing to adjust their current roles and responsibilities to meet the needs of the young child with disabilities.

Special educators and related service personnel may find that they are called on to work in a transdisciplinary fashion with early childhood education staff. Instead of, or in addition to, working directly with the child, special education staff may train early childhood staff to work with the child with disabilities. Early childhood educators may find that they may no longer have total responsibility for the planning of a young child's day. This arrangement requires good consulting, observation, and listening skills from both the early childhood educator and the special educator.

B. Changes in Skills and Knowledge

True collaboration requires the perception of equal benefit from both parties. The knowledge and information to be gained by early childhood educators from the special educators should be balanced by the information on normal child development and the group interaction skills of young children received by the special educators from the early childhood educators. This "cross-training" is an important benefit of integrating young children with disabilities and is crucial to its success. The use of other team members to provide needed expertise rather than one person learning all discipline areas, is a benefit to working as a team.

#3 or #4

C. Changes in Attitudes

It is not easy to change ideas and attitudes. Many staff members, both early childhood educators and special educators, may be reluctant to integrate young children with disabilities into regular early childhood settings. Many may not believe that integrated placements are appropriate for young children with disabilities. The ability to change these types of attitudes requires a belief in the value of integration for young children and the development of a trusting relationship with all the partners in integration.

NOTES

V. WORKING AS A COLLABORATIVE TEAM

#15

KEY IDEA: The collaborative team process is critical to developing and implementing quality integrated programs. A collaborative team relationship involves joint decision making about the future programming for a young child with disabilities. These decisions are made by all of the key team members who are invested or involved in the child's program. Key features of the collaborative team process are described in this section.

#16

A. Definition

A collaborative team relationship involves joint decision making about the future programming of a young child with disabilities by all the key team members who are involved in the child's program. A definition of collaboration follows.

> *Collaboration is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible. Collaboration is based on the simple adages that "two heads are better than one" and that one by itself is simply not good enough!* (Gray, 1989, p 5.)

#17

B. The Collaborative Team Process

The development of a true collaborative team is a process that evolves over time and that requires an effort from all team members. There are five key components to the collaborative team process. Each of the components is described in detail below.

1. Interdependence of Team Members

For the collaborative team to be successful, members must be able to work together to develop solutions that not one could have developed independently. Therefore, there must be interdependence among the team members. It may be necessary to clearly define the interdependence of team members so that the importance of all team members is heightened.

2. Respect and Use Differences

All collaborative team members have different purposes in their participation on the team. They also bring different resources and skills to the collaborative team process. These differences are key to the development of creative solutions to providing integrated options. Team members must show respect for these differences and deal constructively with them.

3. Joint Ownership of Decisions

The collaborative team process should include the joint ownership of decisions. Rather than having an outside entity impose a decision, the team should be responsible for imposing the decision upon itself. Joint ownership of decisions allows for a better understanding of the nature of the issues, and, therefore a decision that meets more of the team's needs. The development of a joint decision involves a joint search for information about the issues, the invention of a mutually satisfactory solution, and the development of plans to implement the solution.

4. Develop Relationships

As a result of the collaborative process, team members develop different relationships with other team members. This dynamic nature of relationships effects how issues will be discussed and resolved in the future. Therefore, practice and experience in working as a collaborative team can lead to better and better collaborative exchanges.

5. Collaboration as an Emergent Process

#5

Collaborative teams do not develop quickly. Collaboration is a process rather than a one-time event. It is an evolving forum for both addressing issues about integrating young children with disabilities into early childhood settings, and for developing new and innovative solutions to providing integrated options.

NOTES

VI. CLOSING DISCUSSION

A. Journal

Ask participants to take five minutes to make an entry in their journal. The entry should relate to their own thoughts and feelings related to the information and ideas discussed in the workshop.

#18

#6

B. Review Field Exercises

To complement the discussion on the roles and responsibilities of adult team members, the trainer may ask the participants to do one or more of the following field exercises. Review possible field exercise with participants. Offer the option to do another activity related to the module themes. Make sure that participants understand the various exercises and their responsibility to complete them.

1. Interviews 3 people who are working in an integrated early childhood setting. Make sure that one of the people is in your discipline area. Ask the following questions: Have their roles and responsibilities changed? If so, how have they changed? What types of new skills and knowledge did they need?
2. Interview 3 people who are currently working as a team in an early childhood setting. Ask the following questions: What are some of the most frequent problems that arise? What solutions are developed to deal with problems? Which solutions depend on change at an individual level and which depend on change at a team level?
3. As a team, identify resources that are available locally to assist with the integration of children into early childhood settings. Bring a list of resources to share with other participants.
4. Generate your own field experience.

#4 - #6

C. Review Particpant and Trainer Expectations and Themes

The purpose of this discussion is to review the participant and trainer expectations in order to ensure that all training needs have been addressed during the session.

D. Review of Future Sessions

Review the next module's content and format with the participants.

E. Workshop Evaluation

Ask participants to complete the workshop evaluation for module three.

NOTES

VII. WORKSHOP EVALUATION

Code: ____________________ **Date:** ________________________

Training Site: ____

Please read the following statements carefully. Rate each statement using the following codes:

1= Strongly Disagree (SD)
2= Disagree (D)
3= Undecided (U)
4= Agree (A)
5= Strongly Agree (SA)

	(SD)	(D)	(U)	(A)	(SA)
1. Overall, the content of this workshop met my expectations.	1	2	3	4	5
2. I gained new knowledge as a result of this workshop.	1	2	3	4	5
3. The workshop was organized and well structured.	1	2	3	4	5
4. I was provided an opportunity to discuss the ideas presented in the workshop.	1	2	3	4	5
5. I was provided with an opportunity to interact with fellow participants.	1	2	3	4	5
6. I gained knowledge about the models of integrated options for young children with disabilities.	1	2	3	4	5

	(SD)	(D)	(U)	(A)	(SA)
7. The workshop provided useful information about the potential changes in my roles and responsibilities that may occur when integrating young children with disabilities.	1	2	3	4	5
8. I gained knowledge of strategies to develop a collaborative team.	1	2	3	4	5
9. I gained knowledge about potential barriers to providing quality integrated settings.	1	2	3	4	5

10. Please identify three of the most significant things you learned as a result of this workshop.

1. ______________________________

____

2. ______________________________

____

3. ______________________________

____

11. What were the strengths of this workshop?

____

____

____

12. In what ways could this workshop be improved?

____

____

____

13. What follow-up needs do you have, if any?

____

____

____

3 MODULE

WHO ARE THE ADULTS?

VIII. TRAINING ACTIVITIES

The following training activities are designed to be used during the third module. For each activity, the Trainer has been provided with the purpose of the activity, a description of the activity, the length of time the activity takes, the materials needed, and the recommended audience size for the activity. A different activity may be substituted as long as it meets the intended purposes of the original activity.

ACTIVITY **PAGE**

1. **Parent/Service Provider Panel Discussion** 25
2. **Discussion of Preschool Options** 26
3. **Role and Responsibility Rubs** 27
4. **Pictiknowledge** 31
5. **The Collaborative Team Process** 33
6. **Barrier Identification** 37

3 MODULE

WHO ARE THE ADULTS?

ACTIVITY #1

PARENT/SERVICE PROVIDER PANEL DISCUSSION

LENGTH OF ACTIVITY

60 minutes

Panel Members:

The 3-5 member panel should be composed of a variety of parents and service providers who are working in integrated settings. The panel may be composed of a parent, his/her child's early childhood teacher, and the child's special educator. Other panel members may include parents who have been looking for more integrated settings, parents of older children who have participated in integrated settings, preschool administrators, special education administrators and parent of nonhandicapped peers, etc. The trainer should establish the panel based on the needs of the audience. Panel members may be recruited from the current training participants or from the community at-large.

Audience:

Large group activity

Purpose: To provide participants with an understanding of the roles, responsibilities, attitudes, and/or feelings of parents and service providers who are working in integrated settings.

Description:

1. The trainer should act as moderator of the discussion.

2. The panel should be given an opportunity to share their stories concerning the integration of young children with disabilities.

3. The participants may wish to have a questions/answer or discussion period with the panel. The following questions may be used by the moderator to facilitate panel discussion.

☆ From a parent perspective, what are the positive and negative aspectsof having a child with disabilities in an integrated early childhood setting?

☆ From a service provider's perspective, what are the positive and negative aspects of having a child with disabilities in an integrated, early childhood setting?

☆ What seemed to be the most difficult part of the responsibility of finding services for your child?

☆ What or who has been **most** helpful in making the integrated setting work? In what way ?

☆ What or who has been **least** helpful in making the integrated setting work? In what way ?

☆ Are there any services, situations, or attitudes that have been a hindrance to you?

☆ What do you want for your child in the future? How can we help?

☆ How can we work together tomorrow to make an integrated setting work for all parties involved—children, parents, educators, and service providers?

ACTIVITY #2

DISCUSSION OF PRESCHOOL OPTIONS

Length of Activity

20 *minutes*

Materials:

No materials are necessary. However, the trainer may wish to use a blank overhead transparency and pens to write down participants' ideas.

Audience:

Large group

Purpose: To provide participants with an opportunity to discuss the options currently being used in the state to provide integrated preschool services to young children with disabilities.

Description:

1. Ask participants to reflect on the types of service delivery systems described. What comments do they have concerning the service delivery systems?

2. To lead the discussion, the trainer may wish to ask questions such as:

☆ If you are currently participating in one of the models presented, how is it working at your site?

☆ What are the advantages and disadvantages of each of the models for your site or county?

Additional Discussion Questions:

ACTIVITY #3 ROLE AND RESPONSIBILITY RUBS

LENGTH OF ACTIVITY

30 *minutes*

Purpose: To provide participants with an understanding of the roles and responsibilities of their fellow participants.

a. To provide an understanding of how roles and responsibilities may change in integrated settings.

b. To provide an understanding of the potential conflicts ("rubs") that may arise from changes in roles and responsibilities.

Description:

1. Ask participants to form groups of two. The participant partners for this activity should not have the same type of background and/or job description.

2. Ask each pair to interview each other and record responses on the *Roles and Responsibility Rubs* handout. The focus of the interview should be on the participants' current roles and responsibilities and the future roles and responsibilities that they may have in an integrated setting. Participants should try to identify the potential "rubs" (areas of difficulty) that may arise as a result of the changes in a more integrated setting.

3. As a large group, discuss the potential "rubs" that may occur as changes occur in roles and responsibilities.

Additional Strategies:

Materials:

Role and Responsibility Rubs handout for each participant

Audience:

Participant pairs and large group discussion

WHO ARE THE ADULTS?

ACTIVITY #3 **HANDOUT: ROLE AND RESPONSIBILITY RUBS**

DIRECTIONS: *Chose a service delivery options that was discussed during the module. If you are currently working in an integrated setting, try to chose one that you are not familiar with. Discuss the service delivery option in terms of the changes you may experience if your program began or changed the way you integrated young children with disabilities. With a partner, list your present roles and responsibilities in the first column. In the second, brainstorm ideas about what changes may occur in the new service delivery option. In the third column, try to identify all the potential "rubs" or areas of conflict that may arise with the new changes.*

Future Service Delivery Option:

PRESENT Roles & Responsibilities	FUTURE Roles & Responsibilities	Potential "RUBS"

ACTIVITY #4

"PICTIKNOWLEDGE"

LENGTH OF ACTIVITY

30 *minutes*

Purpose: To help participants identify their current areas of expertise and the areas of knowledge they may need in a more integrated setting.

Description:

1. Break participants into small groups of 3 - 4 people. Each member of the group should represent a different discipline that you may find involved in the educational program of a young child with disabilities.

2. Ask participants to draw pictures that represent all the knowledge that their team would bring to a family and a child who has a disability. Participants should then draw pictures to represent the types of knowledge they might need to be effective in an integrated setting.

3. Post the pictures and allow time for participants to see each team's poster and discuss the ideas represented.

Additional Strategies:

Materials:

Large sheets of white drawing paper and markers for each team

Audience:

Large and small groups

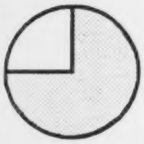
3 MODULE

WHO ARE THE ADULTS?

ACTIVITY #5

THE COLLABORATIVE TEAM PROCESS

Length of Activity



45 *minutes*

Purpose: To provide participants with an opportunity to practice team process skills using case studies.

Description:

1. Break participants into small teams of 3 - 5 people. Each team should represent a variety of different disciplines. Distribute a different case study to each group. Each case study describes the team members involved in the program for a child with disabilities. If a particular discipline or parent is not a member of the team, one team member should be designated to play that role.

2. One team member should be designated as the observer. It is the observer's role to watch and record the interactions of the group as they work through the case study. The observer should use the *Collaborative Team Process Observation Form to record observations.*

3. Each team should read the case study and try to develop strategies for integrating the young child with disabilities into an early childhood setting.

4. Each group should then report back to the large group on the ideas they developed for integrating the child. The observer should report on how decisions were made as a team using the identified components of a team process.

Additional Strategies:

Materials:

A copy of one of the case studies and a copy of the *Collaborative Team Process Observation Form* for each team.

Audience:

Large and small groups

316

ACTIVITY #5

HANDOUT: THE COLLABORATIVE TEAM PROCESS ACTIVITY

CASE STUDY I

Emily is a four year old child with a diagnosis of Cerebral Palsy. She was a premature infant with a history of seizure activity. Emily has also been diagnosed with hydrocephalus and currently has a shunt. She has experienced several surgeries to replace her shunt, reduce the spasticity in her lower extremities and to correct her vision (strabismus). Emily is able to communicate verbally in two and three word sentences but is often very shy in new environments. She is toilet trained but needs assistance with dressing and moving to the bathroom. She can feed herself with minimal assistance. Emily can crawl and is beginning to manipulate her wheelchair. Emily enjoys other children and is often motivated by their performance. She is a hard worker and will try to complete tasks although she is somewhat distractible. Emily likes music and can manipulate a tape recorder. Her siblings at home provide her with opportunities to play with and share toys.

TEAM MEMBERS NEEDED:

Grandmother (primary caregiver during day)

Mother (primary caregiver in evenings)

Special Educator

Physical Therapist

Observer

Child Care Center Teacher

TEAM BACKGROUND:

Emily's grandmother is concerned that Emily have an opportunity to play with other children her own age. She is also concerned that Emily does not seem to be learning to talk as quickly as she should be. Emily's mother feels that speech is not an issue at this point, however she is very concerned that Emily begin to start walking soon. The special educator wants to try to integrate Emily into a local child care center. However, the child care center teacher is concerned that she can not meet all of Emily's needs, and about Emily's history of seizures. The physical therapist is against any type of integrated placement for Emily. It would be too difficult to provide physical therapy to Emily if she is not located at the segregated preschool program where the physical therapist works.

TEAM GOAL:

As a team discuss the possible options for providing services to Emily and her family. What types of services will Emily and her family like, and how can these services be provided to?

ACTIVITY #5

HANDOUT: THE COLLABORATIVE TEAM PROCESS ACTIVITY

CASE STUDY II

David is a three year old child with Down Syndrome. He also has a history of frequent middle ear infections and upper respiratory infections. David is beginning to communicate using sign language and verbal approximations ("wa" for water or drink, "ba" for ball). His social and play skills appear similar to a young two year old. David is not toilet trained and needs assistance with dressing. He eats and drinks independently. David is happiest playing on the swings and in the sandbox.

TEAM MEMBERS NEEDED:

Father (single parent)

Child Care Center Teacher

Special Educator

Speech Therapist

Observer

TEAM BACKGROUND:

David's father has had David enrolled in Mrs. Smith's child care center for the past two years. He is happy with the arrangement because it fits his work schedule. David's father has been taking his son to private physical and speech therapy during lunch breaks twice each week, but now would like to see the services provided by his local school district. The school district has recommended that David attend the early intervention program that is currently in place. The early intervention program is run by the special educator and the speech therapist. It is held Monday - Thursday mornings with home visits on Friday mornings.

TEAM GOAL:

As a team discuss the possible options for providing services to David and his family. What types of services will David and his family like, and how can these services be provided?

WHO ARE THE ADULTS?

ACTIVITY #5

HANDOUT: THE TEAM COLLABORATIVE PROCESS

CASE STUDY III

Jamie is a four year old child with autistic-like behaviors. He does not communicate verbally with speech or any augmentative communication system. Jamie does not "play" with toys but prefers to spin or manipulate toys in atypical ways. He laughs frequently and has difficulty attending or sitting for any length of time. Jamie does not enjoy being touched or held by others but may occasionally initiate some interaction (usually a touch). He is not toilet trained and needs assistance with dressing. Jamie eats and drinks independently but may chose to "play" with his food or drink. Jamie appears to adapt most easily to a very structured and consistent environment.

TEAM MEMBERS NEEDED:

Mother and Father

Child Care Center Administrator

Observer

Psychologist

Special Educator

TEAM BACKGROUND:

The team has met previously, and determined that Jamie would receive services at the child care center. However, since that time, there has been turn-over in the special education and child care staff. As a result, Jamie has a new child care center teacher and a new special education teacher. During the interim period between staffs, no services were provided to Jamie. The child care administrator is concerned because of the lack of assistance from the school system and because of the complaints about Jamie's behavior from other parents of children attending the center. Jamie's parents are concerned because they have organized their work schedules around the child care center's hours. If any changes are needed as to when and where Jamie receives services, it will cause many problems for the family. While his parents are willing to do all they can to help Jamie, the scheduling problems may be severe enough that one of the parents may have to quit work. This is not a viable option for their family.

TEAM GOAL:

As a team discuss the possible options for providing services to Jamie and his family. What types of services will Jamie and his family like , and how can these services be provided?

ACTIVITY #5

HANDOUT: THE TEAM COLLABORATIVE PROCESS ACTIVITY

CASE STUDY IV

Teddy is a four year old child with a diagnosis of microcephalus and vision difficulties including visual acuity measures of 20/100 (R) and 20/200 (L), bilateral colobomas and congenital nystagmus. He wears glasses which provide significant acuity correction. He has social and cognitive functions similar to a two year old. He is not toilet trained and requires assistance with dressing. Teddy can eat independently. He is very echolalic in his verbal expression but appears to understand many verbal requests. Teddy often needs to have verbal cues to initiate any communication. Teddy also displays self-stimulatory behaviors such as rubbing his hands under his chin.

TEAM MEMBERS NEEDED:

Mother and Father

Special Education Teacher

Vision Specialist

Family Child Care Provider

Observer

TEAM BACKGROUND:

Due to a company transfer, Teddy's mother and father have recently moved into the area. Both parents work during the day. The parents prefer to have Teddy in a family child care home rather than a center, and feel happy with the family child care provider they have found. The family child care provider is very willing to have Teddy in her home. However, she is concerned about Teddy's lack of communication skills, and wants to make her home safe for Teddy, given his vision impairments. The special educator and the vision specialist, both of whom provide services in a center for children with disabilities, have never before worked together. The special educator and the vision specialist would like to work more closely, and perhaps provide services in the family child care home. However, they are not at all sure how to begin providing services outside their center.

TEAM GOAL:

As a team discuss the possible options for providing services to Teddy and his family. What types of services will Teddy and his family like, and how can these services be provided?

ACTIVITY #5 HANDOUT: THE TEAM COLLABORATIVE PROCESS ACTIVITY

CASE STUDY V

Jackie is six years old with multiple impairments. She has cerebral palsy (spastic quadriplegia), a seizure disorder and questionable vision (cataract at birth). Hearing appears to be normal. Jackie is fed by a gastric tube and cannot take anything by mouth. She uses a wheelchair, and has very limited motor control. She makes random sounds, but no consistent verbalization. Jackie is not toilet trained and needs total assistance for dressing. She smiles consistently to music and appears to enjoy (smiles) being around other children and simple activities.

TEAM MEMBERS NEEDED:

Mother	**Nurse/Dietician**
Physical Therapist	**Child Care Teacher/Administrator**
Observer	**Public School Teacher**

TEAM BACKGROUND:

The child care center teacher saw an article in the newspaper about day care for young children with disabilities and would like to have a child with disabilities in her center. However, she has no idea what type of preparations she may need to make. The child care teacher is also concerned about her licensing requirements in regards to children who are not toilet trained. Jackie's mother heard about the child care teacher's willingness to integrate young children with disabilities through a neighbor. Jackie's mother needs after-school child care and would like her daughter to have the opportunity to interact with other children. She is however very concerned about Jackie's health and safety while she is at the child care center. The physical therapist currently provides services at the school.. He is willing to provide therapy services in the child care center but does not know if his liability insurance will cover him at another site. The nurse/dietician is very concerned that the child care center staff be able to manage Jackie's medical needs, especially the tube feedings which must be done every three hours.

TEAM GOAL:

As a team discuss the possible options for providing services to Jackie and her family. What type of services will Jackie and her family like, and how can these services be provided?

DIRECTIONS:

ACTIVITY #5

HANDOUT: COLLABORATIVE TEAM PROCESS OBSERVATION FORM

Cite examples of each of the following collaborative team characteristics.

Interdependence of Team Members

Respect and Use Differences

Joint Ownership of Decisions

What strategies did the team use tht were the *most* effective in meeting their team goals?

What interactions/attitudes were the least effective in helping the team meet their team goals?

WHO ARE THE ADULTS?

ACTIVITY #6 **BARRIER IDENTIFICATION**

Length of Activity

30
minutes

Materials:

Post-it® notes or index cards and tape

Audience:

Large group discussion

Purpose:

a. To provide participants with an opportunity to discuss potential barriers to providing integrated settings in their own communities.

b. To provide participants with an opportunity to generate potential solutions to identified barriers.

Description:

1. Facilitate a brainstorming discussion of potential barriers to integration.

2. Write each identified barrier on an index card as participants generate them. Tape or fasten each barrier to the wall. If solutions are generated to the barriers, write them down on the appropriate index card.

3. At the end of the session, the trainer should collect the cards for the next session.

4. The trainer may wish to use the following list of potential barriers if participants have difficulty identifying barriers or seem to have difficulty identifying possible key barriers.

Additional Strategies:

ACTIVITY #6

BARRIER IDENTIFICATION

A. Personal Barriers: Those barriers that relate specifically to the individuals involved in integrating a young child with disabilities into an early childhood setting. The barriers are related to the staff and the child with disabilities.

1. Attitudes of Staff Concerning Children with Disabilities: Staff may not feel comfortable with the idea of integrating a young child with disabilities into an early childhood setting. Other staff may feel comfortable with some children with disabilities but not with others. Comments such as "He'll be a bad influence on the other children," or "She has too many motor difficulties to be in my classroom," or "He is too disabled to be in that setting," may be a key to identifying these barriers.

2. Attitudes of Staff Concerning Potential Role Changes: Integrating young children with disabilities into early childhood settings may involve role changes for both early childhood educators and support service staff. Some staff may be reluctant to make the changes that will be necessary to insure that the integration of the young child with disabilities is successful.

Changes will have to be made where staff work, how staff work and what staff do with children. These changes may bring out a sense of territorialism in staff that can be a barrier to integration.

3. Qualifications of Staff: Staff may not feel qualified to work with young children with disabilities in integrated settings. This may only be a barrier if the staff is unwilling or unable to develop additional skills and knowledge. Barriers may also occur if staff is unwilling to cross-train in their area of expertise.

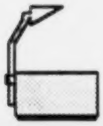
B. Programmatic Barriers: Programmatic barriers relate to the setting where the integration is to occur. Barriers to integration may exist due to the building, people who interact with the child with disabilities, and/or with the changes in programming and staffing that may be needed to fully support integration.

1. Physical Plant Barriers: Barriers may exist that limit integration because of the physical structure of the building or classroom. Examples of these barriers include: stairs for a child who is nonambulatory, poor acoustical environments for a child with a hearing impairment or a child who cannot tolerate noise, or lack of adequate lighting for a child with visual impairments.

2. Attitudes of Persons in the Environment Toward Children with Disabilities: Other staff, families, and peers may present barriers to integration if care is not taken to prepare them for the integration of a young child with disabilities. Comments such as "I don't want him in my child's class," may be identified as barriers to integration.

3. Changes in Programming: Changes in the way both early childhood personnel and support service personnel work may be necessary. Although staff may be willing to make these changes, the changes may not be supported by the programs/agencies that provide services to young children with disabilities. Barriers may occur if agencies are not willing to make changes in staffing patterns, roles and responsibilities to meet changes in programming. Barriers may also include funding sources, liability issues and transportation issues.

C. Community Barriers: Other barriers exist that are not under the control of the staff or the program/agency where they work. These barriers relate to the community as a whole. Some of these barriers may include: the rules and regulations of both child care and special education services, including: certification issues, the availability of programs and services, and issues related to liability, funding and transportation at the community level.



3 MODULE

WHO ARE THE ADULTS?

IX. OVERHEAD TRANSPARENCIES

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Module Three: Outline of Training

- Current Guidelines for Services to Young Children 0-8
- Role Changes in Integrated Settings
- Working as a Collaborative Team

2

Module Three: Purpose

- To provide information on options for integrated programs, and to identify the roles, responsibilities and expertise of the adult team members including parents, early childhood educators, special educators and other support service staff.

3 Module Three: Goals

- To identify and discuss current options for providing integrated settings for young children with disabilities.
- To identify and discuss the changes needed in roles, responsibilities, expertise and attitudes of adult team members in order to implement quality integrated programs.
- To identify and discuss potential strategies for working as a team to integrate a young child with disabilities into a regular early childhood settings.

4 Module Three: Participant and Trainer Expectations

- The Trainer will provide participants with the:
  - information related to the current options used in Ohio to integrate young children with disabilities into early childhood settings
  - information defining the professionals' future roles, responsibilities and expertise that will be necessary in order to facilitate the integration of young children with disabilities in early childhood settings.
  - information designed to discuss the benefits of the team process and strategies to develop teaming skills.

5 Key Themes

- Environments for all learners need to be emotionally secure and physically safe
  - Secure relationships enhance learning
  - Accurate, understandable information enhances the learning environment
  - Within a secure environment we are both teachers and learners
  - Autonomy and decision making abilities support learning

6 Key Themes: (cont.)

- Learning can be enhanced through individualization
  - Individualization can and does occur within group settings
  - Social interactions with a variety of peers and adults can enhance learning
- All learners have a variety of strengths and needs
  - You don't have to segregate to teach
  - You don't have to segregate to learn

7 Key Idea: Models of Providing Integrated Options

- The current guidelines through the Departments of Health and Education for services to children between the ages of 0-8 years in Ohio allow for a variety of integrated options for placement and delivery of services. This section will provide some background and discussion of the types of services delivery currently within the regulations.

8

Early Childhood Planners' Conference

- "Most Supportive" rather than the "Least Restrictive" Environment.
- Placement based on the question. "Where would this child be if he/she were not handicapped?".
- Parallel policies should be developed for the 0-2 & 3-5 year old child.
- "Regular" and "Special Early Childhood" teacher certification should be made either identical or reciprocal.
- Amend policy/regulatory barriers to the use of private placements
- Consider the integration of the child into the family, the family into the community and, finally, the child into a program
- The public's awareness regarding these issues must be raised

9 Services to Infants and Toddlers 0-2 in Ohio

- "Least Restrictive Environment" means an environment in which an infant or toddler receives early intervention services with other children who are not infants and toddlers at risk, that is used for an infant or toddler only when the nature and severity of the disabling condition of the infant or toddler prevents satisfactorily achieving the goals of the early intervention service for the infant or toddler in normal environmental settings, and is the environment in which the infant or toddler should receive early intervention services if he were not an infant or toddler at risk. (Section 3714.01, O)

10

Preschool Regulations for Young Children 3-5 years in Ohio

- "(1) Itinerant services which may be delivered in the home environment or to a child attending a preschool/ kindergarten program administered by a public school or a child attending a community-based preschool/kindergarten or child-care program that meets the requirements of Chapter 5104 of the revised code and where a qualified preschool staff member is assigned to the child; and

- (2) Special class located in an integrated or separate facility." (Chapter 3301-31, Section 03,C)

Regulations for Children 6-8 years in Ohio

- Supplemental Services Teacher
- Individual/Group Instruction
- Special Class in Age-Appropriate Public School

12

Models of Service Delivery

- Itinerant Services in an Integrated Setting
- Classroom Services in an Integrated Setting
- Enrollment of Nonhandicapped Peers
- Early Childhood Centers

13 Key Idea: Role Changes in Integrated Settings

- Providing services to young children with disabilities in integrated settings may mean a variety of changes for families early childhood educators, special educators, and other professionals. Changes may need to occur in the roles, responsibilities, skills, knowledge and attitudes of all participants in the integration process. This section describes the changes that may be necessary and some potential strategies to assist in the transition process.

14 Changes in Integrated Settings

- Changes in Roles and Responsibilities
- Changes in Skills and Knowledge
- Changes in Attitudes

15 Key Idea: Working As A Collaborative Team

- The collaborative team process is critical to developing and implementing quality integrated programs. A collaborative team relationship involves joint decision making about the future programming for a young child with disabilities. These decisions are made by all of the key team members who are invested or involved in the child's program. Key features of the collaborative team process will be describe in this section. (TIME)

16 Definition: Collaboration

- Collaboration is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible.
  Collaboration is based on the simple adages that "two heads are better than one" and that one by itself is simply not good enough!

- (Gray, 1989, p 5.)

17 The Collaborative Team Process

- Interdependence of Team Members
- Respect and Use Differences
- Joint Ownership of Decisions
- Develop Relationships
- Collaboration as an Emergent Process

18

Field Exercises

- Interview three people who are working in an integrated early childhood setting. Make sure that one of the people is in your discipline area. Ask the following questions: Have their roles and responsibilities changed? If so, how have they changed? What types of new skills and knowledge did they need?
- Interview three people who are currently working as a team in an early childhood setting. Ask the following questions: What are some of the most frequent problems that arise? What solutions are developed to deal with problems? Which solutions depend on change at an individual level and which depend on change at a team level?
- As a team, identify the resources that are available locally to assist with the integration of children into early childhood settings. Bring a list of resources to share with other participants.
- Generate your own field experience.

3 MODULE

WHO ARE THE ADULTS?

X. SUMMARY PAPERS

TITLE **PAGE**

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2. **Effective Consultation** 89

3 Summary Papers

3 MODULE

WHO ARE THE ADULTS?

PARENTS ON THE TEAM

Leah Holden

Family First Project

New Lexington, OH

One criterion for excellence in early childhood programs is a family-centered approach. This means that the family is at the center of programs and services, and the family's strengths, concerns and priorities determine what services and supports are offered, when, where and how. Parents are not expected to "place" their children in programs or to adjust their lives and their values to demands of the service. Rather, service workers organize and mobilize resources around the family, so that the family's values, routines and expectations can be preserved and respected.

In family-centered services family members are central in planning. Plans for children build on the family's visions and dreams for the future. Goals and objectives are formulated in parent language, rather than professional jargon. Professionals become assistants, consultants, supporters and encouragers of parents, as families discover and pursue their goals for the future.

Collaborative planning with parents, however, is a goal more often hoped for than achieved. Despite professionals' intentions to encourage parental involvement in their child's program, it seems that parents' and professionals' ideas about parent involvement are not at all similar.

Parents and professionals frequently point to each other as the source of difficulties in getting what a child needs. Professionals may focus on parents who seem ill-prepared or uncooperative. Parents, in turn, may emphasize that service systems do not meet their or their child's needs adequately. An approach that seeks to fix blame for the problem holds little promise for creating services and supports needed by children and their families, and it generally has the effect of creating resentment.

Parents and professionals may indeed have quite different perspectives on what is helpful for a child. Professionals bring with them specialized knowledge in a particular field and a focus on what is going on with the child in the present. Parents, on the other hand, must attend to all of the child's needs, now and in the future.

The chances of realizing a bright future for a child are greatest when parents are able to share their dreams and find others who will dream with them. Professionals who serve the child become important allies when they share a vision of the child's future. This means that they encourage parents to envision a positive future for their child and that they respect parents' decisions about the future, even when those decisions are different from what the professionals might choose.

The roles of dreamer and planner, like other important roles adults play in the lives of children — nurturer, teacher, consultant, advocate, etc. — are shared between parents and the professionals who know and serve their children, but these roles may not always be shared equally. Both parents and professionals nurture children; both also teach. Each may carry out their roles in different proportions and in different ways.

What seems to be required for parents and professionals to form true partnerships is not that parents become like professionals by adopting professional language or ways of dealing with children or that professionals abandon their training and expertise, but that parents and professionals come together in mutual respect and appreciation. Respect for the other person as a valued equal is one of the principles that can transform working relationships into true partnerships. Others include:

- Appreciation for social factors, including devaluation and segregation, that have an impact on families;

- Understanding the delicate balance between a child's and a family's needs and the services and supports available to meet these needs;

- Sensitivity to parents' needs for a variety of services and supports, including empowerment;

- Encouragement and assistance for parents to develop future plans for their children that are based on optimism about development and high expectations for quality of life;

- Expectations of children (and their families) that are based on sound ideas about learning and development;

- Sharing of roles, though sometimes in different proportions and with different focus or emphasis;

- Willingness to engage in relationships that may be difficult or complicated.

Further reading

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3 MODULE

WHO ARE THE ADULTS?

EFFECTIVE CONSULTATION

Dennis Sykes

Center for Special Needs Populations

Columbus, OH

The integration of young children with disabilities into community early childhood programs requires the support of knowledgeable individuals acting in a consultant role to program staff. The willingness of child-care programs to accept young children with disabilities has been documented by Berk and Berk (1982). This willingness is qualified by a need for adequate support of child-care staff in this endeavor. In order for this support to occur, early childhood special education, early intervention, and related service personnel need to be able to communicate their knowledge of young children with disabilities. The effective communication of this knowledge can be described as consultation.

Brown, et al (1979) define consultation as

> *"a process based upon an equal relationship characterized by mutual trust and open communication, joint approaches to problem identification, the pooling of resources to identify and select strategies that will have some probability of solving the problem that has been identified, and shared responsibility in the implementation and evaluation of the process or strategy that has been initiated."* (p. 8)

The notions of "shared responsibility" and "equal relationship" described above are crucial to the success of a consulting relationship. The relationship must be of a 2-way nature to be successful. This requires, on the consultant's part, sensitivity to the consultee, their setting and its requirements

Heron and Harris (1987) suggest that the consultant role in education settings could be described as requiring 3 major skill categories: providing technical assistance, communication, and coordination. The authors also observe that the literature on education consultation demonstrates that successful consultation outcomes are achieved when (a) accurate problem identification occurs, (b) consultants and consultees work collaboratively on mutually recognized goals; (c) establish credibility and trust; (d) provide feedback; and (e) disseminate information.

The successful consultation described above may not be easily achieved due to a number of barriers which must be overcome prior to and during the consultation process. According to Johnson, Pugach and Hammitte (1988) these barriers can be categorized as: Pragmatic barriers (insufficient time and overwhelming caseloads) and Conceptual barriers (credibility, orientation match between consultant and consultee, organizational structure of the existing program, differential knowledge base between consultant and consultee). West (1988) suggested that effective consultation is often hampered when (a) there is insufficient time to conduct the consultation; (b) administrative support is lacking; (c) teacher's or other staff do not perceive the process or potential outcomes positively; (d) little effort is made to promote consultation behavior with staff; and (e) the consultant or consultee lacks the necessary skills to engage in the process.

The most important elements in overcoming the barriers described above are the dedication of adequate time and support for the process as well as a willingness of the participants to work collaboratively on mutual goals.

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4 MODULE

PROBLEM SOLVING STRATEGIES & PREPARATION FOR INTEGRATION

TRAINER'S NOTES

4 MODULE

PROBLEM SOLVING STRATEGIES AND PREPARATION FOR INTEGRATION

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4 MODULE

PROBLEM SOLVING STRATEGIES & PREPARATION FOR INTEGRATION

TRAINER'S NOTES

I. MODULE OVERVIEW

LENGTH OF TRAINING

This module is designed to be completed in one 3 1/2 hour session, including approximately 30 minutes for breaks. Breaks should be inserted in the training as needed. The trainer should provide time either during the breaks or at the end of the session for the completion of continuing education credit forms and the final evaluation.

A. Purpose and Goals

Purpose: To provide information on problem solving skills and to provide solutions to identified barriers to integration.

Goal 1: To provide information on techniques for identifying and clarifying problems and developing creative solutions to problems.

Goal 2: To provide information on common solutions and strategies for preparing the entire early childhood setting for the integration of a young child with disabilities.

B. Trainer and Participant Expectations

1. The trainer will provide participants with information enabling them to identify strategies that will help facilitate the development of their future role and responsibilities.

2. The trainer will provide participants with information enabling them to identify methods for preparing the child with disabilities and his/her family for integration into an early childhood setting.

3. The trainer will provide participants with information enabling them to prepare other children and families in the child care setting for the integration of a young child with disabilities.

4. The trainer will provide participants with information enabling them to identify key community resources for integrating a young child with disabilities.

5. The trainer will provide participants with information enabling them to develop problem solving skills related to the integration of young children with disabilities.

4 MODULE

PROBLEM SOLVING STRATEGIES & PREPARATION FOR INTEGRATION

II. SUMMARY TRAINING OUTLINE

LENGTH OF TRAINING FOR EACH SECTION

The summary training outline is provide to trainers as an organizing tool. It describes the basic outline of the content and describes appropriate places for training activities and the presentation of audiovisual materials. A space has also been provided for making notes about materials, equipment and other training needs.

Key:

- Activity **- Overhead**

---

30 minutes

Opening Discussion #1-#3

- Review of Module Purpose, Goals, Expectations & Themes #1
- Review Field Exercises

2 Hours

Barrier and Solution Identification #4-#5

- Clarifying Barriers #2 or #3
- Generating Solutions

30 minutes

Closing Discussion #4

- Journal
- Continuing Education Credit
- Collect Workshop Evaluations

370

4 MODULE

PROBLEM SOLVING STRATEGIES & PREPARATION FOR INTEGRATION

III. BARRIER AND SOLUTION IDENTIFICATION

#4

KEY IDEA: There are often many barriers to the integration of young children with disabilities into regular early childhood settings. Some of the barriers may be easily solved, while others may take a more long-term, coordinated effort. The focus in this section is to further discuss the identified barriers to integration and to identify potential solutions to those barriers.

A. Clarifying Barriers

Often, many barriers can be identified that prevent young children with disabilities from being integrated into regular early childhood settings. Some of the barriers can look overwhelming and can be discouraging for those who are trying to make changes. It can be beneficial to examine each barrier closely in order to determine if the impact of the barrier is worth the effort that might be necessary in order to effect any change.

#5

#2 or #3

B. Generating Solutions

Many barriers to integrated placements are unique to a particular family, program, staff, community, or county. However, some solutions may be useful in a number of different sites. The following description of potential solutions is not all inclusive, but it may provide a useful starting point for discussion.

1. Preparation of the Child with Disabilities

Movement to new settings is very difficult for young children. It may be even more difficult for a child with disabilities if he/she has difficulty communicating or difficulty in understanding his/her environment. Therefore, it is important to prepare the child with disabilities for the integrated placement. The first step in the preparation process is to work with all team members to collaborate on planning for the child. The second step is to introduce the child with disabilities to the setting. For example, a child may visit his new "school" with his family before the initial enrollment day.

2. Preparation of Other Young Children in the Environment

Other young children in the early childhood setting should be prepared for the integration of a peer with disabilities. During play activities, the teacher should use books, pictures, and puppets to describe the new child with a disability. The *New Friends* training manual is a good resource for activities. Overall, the teacher should insure that the setting is safe enough so that children will feel comfortable asking questions. By observing behaviors and listening carefully, the teacher can insure that all children are adapting to the new child.

3. Preparation of Other Adults in the Environment

Adults may have as many, if not more, questions about the new child than their children. Preparation is necessary in order to alleviate apprehensions, facilitate competent care, create open communication and relationships with the new family, and create a safe, responsive environment. Information should be provided to other adults via written materials, audio-visual materials, and discussions.

4. Solutions to Personal Barriers

Personal barriers are often solved through the provision of information. Therefore, the preparation strategies listed previously may solve some of these barriers. Other issues related to barriers may be resolved through collaboration and support from the team, the agency or program and community resources.

5. Solutions for Programmatic Barriers

Physical plan adaptations (e.g., ramps, adaptive equipment, etc.) may be a way to alleviate many programmatic barriers. Again, support from the program and community through volunteered time and resources may help with funding issues. Administrative support for integration is crucial and may be facilitated through the provision of information. Team collaboration will also facilitate many programmatic barriers.

6. Solutions to Community Barriers

Community barriers are often some of the most difficult to change. The change is difficult to facilitate because the barriers are often under another person's control. As noted in the discussion of some of the key issues regarding integration, positive solutions to community barriers can have great impact on the child with disabilities and the child's family.

☆ Certification/Regulation issues: At the present time, many of the certification/regulation issues surrounding the integration of young children with disabilities are being newly developed or revised. This may allow programs an opportunity to experiment with possible strategies. Communication of ideas to the involved state departments will insure that information and concerns are communicated. Letter writing is another way to effectively get a message to the appropriate party(ies).

☆ Liability issues: Many of the issues related to liability concerns are individual to a particular situation and insurance company. If a service provider has any concerns regarding this issue, they should be encouraged to discuss them directly with the appropriate insurance company. Often staff training and releases signed by parents may help resolve liability barriers. Information about the availability of medical help (medics, school nurse, hospital) may also help address some liability issues.

PROBLEM SOLVING STRATEGIES & PREPARATION FOR INTEGRATION

III. BARRIER AND SOLUTION IDENTIFICATION (cont.)

☆ Transportation issues: Transportation issues often can be mediated by investigating local community resources. The Red Cross, Senior Citizen programs, or public school buses may be able to assist in transporting children. Car pooling within a particular school or agency is another alternative that should be considered. In addition to addressing the transportation issue, new relationships also develop as a result of car pooling.

☆ Funding issues: While the federal government has ruled that tuition fees may be provided to child care settings for the time necessary for implementation of the IEP, Ohio public schools cannot contract with private agencies for educational services. This issue is still being discussed. However, other forms of funding (e.g., Title 20) should be investigated by identifying community resources.

PROBLEM SOLVING STRATEGIES & PREPARATION FOR INTEGRATION

IV. CLOSING DISCUSSION

#4

A. Journal

Ask participants to make a final entry into their journals. If time allows, the trainer may wish to generate a discussion of ideas that were generated through the use of the journal.

B. Continuing Education Credit

The trainer should provide time for participants to complete continuing education credits as needed.

C. Workshop Evaluation

Ask participants to complete the final workshop evaluation.

4 MODULE

PROBLEM SOLVING STRATEGIES & PREPARATION FOR INTEGRATION

IX. WORKSHOP EVALUATION

Code: ____________________ Date: ________________________

Training Site: ____

Please read the following statements carefully and rate each statement using the following codes:

1= Strongly Disagree (SD)
2= Disagree (D)
3= Undecided (U)
4= Agree (A)
5= Strongly Agree (SA)

	(SD)	(D)	(U)	(A)	(SA)
1. Overall, the content of this workshop met my expectations.	1	2	3	4	5
2. I gained new knowledge as a result of this workshop.	1	2	3	4	5
3. The workshop was organized and well structured.	1	2	3	4	5
4. I was provided an opportunity to discuss the ideas presented in the workshop.	1	2	3	4	5
5. I was provided with an opportunity to interact with fellow participants.	1	2	3	4	5
6. I gained knowledge about the possible ways to generate solutions to potential barriers.	1	2	3	4	5

	(SD)	(D)	(U)	(A)	(SA)
7. I gained knowledge about strategies for preparing peers, families, and staff for the integration of a young child with disabilities.	1	2	3	4	5
8. The workshop provided useful information on strategies to solve potential barriers to integration.	1	2	3	4	5
9. I gained knowledge about the potential Community Resources that can assist with the integration of young children with disabilities.	1	2	3	4	5

10. Please identify three of the most significant things you learned as a result of this workshop.

1. ______________________________

2. ______________________________

3. ______________________________

11. What were the strengths of this workshop?

____

12. In what ways could this workshop be improved?

____

13. What follow-up needs do you have, if any?

____

4 MODULE

PROBLEM SOLVING STRATEGIES & PREPARATION FOR INTEGRATION

VI. TRAINING ACTIVITIES

The following training activities are designed for use during the fourth module. For each activity, the trainer has been provided with the purpose of the activity, a description of the activity, the length of time the activity takes, the materials needed, and the recommended audience size for the activities. A different activity may be substituted as long as it meets the intended purposes of the original activity.

ACTIVITIES **PAGE**

1. **Integration Questionnaire** 14
2. **Spheres of Influence** 17
3. **Likelihood/Impact Analysis** 23
4. **Commitment to Action** 27

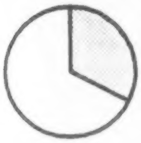
4 MODULE

PROBLEM SOLVING STRATEGIES & PREPARATION FOR INTEGRATION

ACTIVITY #1

INTEGRATION QUESTIONNAIRE

LENGTH OF ACTIVITY



20 minutes

Purpose: To provide participants with an opportunity to reflect upon their attitudes concerning the integration of young children with disabilities into the regular education classroom, and to share their beliefs, ideas, and concerns with other participants.

Description:

1. Ask each participant to complete the *Integration Questionnaire.*

2. As a large group, discuss some of the answers to the questionnaire. Remind participants that there is no wrong or right answer to any of the questions.

3. Faciliate the discussion by asking questions such as:

   a. Which questions were most difficult to answer and why?

   b. Which questions were the easiest to answer and why?

   c. Did any of your answers surprise you? Why

   d. How have your answers changed since the first session?

Additional Discussion Questions:

Materials:

One *Integration Questionnaire* for each participant

Audience:

Individual and large group activity

ACTIVITY #2

HANDOUT: INTEGRATION QUESTIONNAIRE

Date: ____________________

1. The key reason for integrating young children with and without disabilities is...

2. When working with a young child who has a disability, the most critical concerns are...

3. The greatest obstacle to successful integration of young children with disabilities into community early childhood programs is...

4. Young children react to children with disabilities by...

ACTIVITY #2 SPHERES OF INFLUENCE

LENGTH OF ACTIVITY

2 *HRS*

Purpose: To provide participants with a tool to facilitate discussing and brainstorming of possible solutions to identified barriers.

Description:

1. Disseminate a copy of the previously identified barriers to each participant. Each barrier should be labeled with a letter for ease in identification. Briefly review each of the barriers with the participants.

2. Divide the participants into small groups of 3 - 5 people. Give each group a *Sphere of Influence* overhead and transparency pen. Ask each group to place the number cooresponding to each barrier into one of the three circles on the overhead: "What we control;" "What we influence;" and, "What we neither control nor influence." Give participants approximately 1/2 hour to complete this task.

3. As a large group, discuss the results of the small group exercise. Using the transparency to facilitate discussion, a representative from each small group may present their results to the large group.

4. Using the *Solution Identification* worksheet, ask each group to brainstorm possible solutions to the identified barriers. Ask participants to work first with barriers within the center circle ("What we control") and then work to the second circle ("What we influence"). Some discussion should be generated as to why it would not be effective to identify solutions to the barriers in the outer circle ("What we neither control or influence").

5. When the group has finished identifying potential solutions review ideas as a large group. The trainer may wish to collect all the worksheets, compile and the information and disseminate it to all participants.

Additional Strategies:

Materials:

A copy of the previously identified barriers for each participant, 5 transparencies of the *Sphere of Influence* sheet, 5 overhead transparency pens, 5 *solution identification worksheets* (1 for each group)

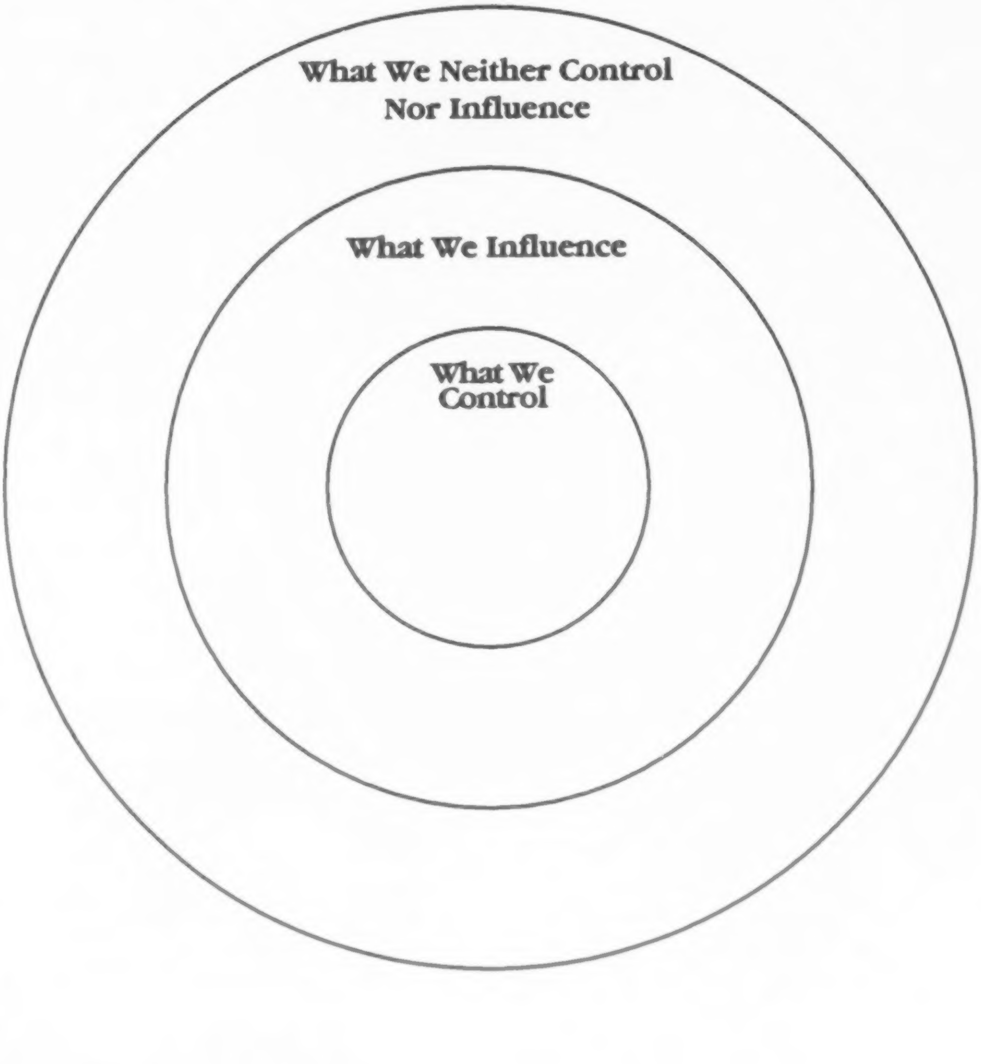
Audience:

Small and large group activity

Adapted from : L. Edelman, Project Copernicus, The Kennedy Institute.

ACTIVITY 2 | OVERHEAD: SPHERE OF INFLUENCE

Directions: Place the letter corresponding to each barrier within the appropriate circle.


What We Neither Control
Nor Influence
What We Influence
What We
Control

ACTIVITY 2

HANDOUT: SOLUTION IDENTIFICATION WORKSHEET

BARRIER	POTENTIAL SOLUTIONS

ACTIVITY #3

LIKELIHOOD/IMPACT ANALYSIS

LENGTH OF ACTIVITY

2 *HRS*

Materials:

A copy of the identified barriers for each participant, a copy of the *Likelihood Impact Analysis* form for each participant, 5 transparencies of the *Likelihood Impact Analysis* form, 5 different colored overhead transparency pens.

Audience:

Large and small group acivity

NOTE:

If many barriers have been identified or if only a little time is left, have different groups start rating different barriers. For example, Group 1 could start at the top of the list, and Group 2 could start at the bottom.

Purpose: a. To provide participants with an opportunity to discuss potential barriers to providing integrated settings in their own communities.

b. To provide participants with an opportunity to generate potential solutions to identified barriers.

Description:

1. Review the previously identified barriers with participants. Ask if any barriers are missing or if any are no longer barriers.

2. Divide participants into 4-5 small groups. Give each group an overhead transparency of the likelihood impact analysis form and an overhead transparency pen.

3. Each group should review the barriers and ask themselves two questions about each one: 1) What is the likelihood of this barrier being resolved?; and, 2) If the barrier were resolved, what would be the impact on the provision of integrated settings for young children with disabilities? For each question, the participants should rate the likelihood of the barrier existing in their particular setting, and the barrier's impact on integration. Participants should use a rating scale from 1 (very low likelihood or impact) to 5 (very high likelihood or impact). Each group's ratings should be marked on the likelihood/impact transparency.

4. After rating each barrier, the group should discuss potential solutions to each barrier. Use the solution identification worksheet.

5. When ratings of all the barriers have been completed, participants should discuss their ratings as a large group. The trainer should facilitate discussion around the following questions:

   a. Which barriers are the easiest to change and will have the greatest impact? (i.e., high scores on both impact and likelihood)

   b. Which barriers are the hardest to change and will have the least impact? (i.e., low scores on both impact and likelihood)

6. As a large group, discuss the solutions that were identified during the small group activities.

PROBLEM SOLVING STRATEGIES & PREPARATION FOR INTEGRATION

ACTIVITY #3 **LIKELIHOOD/IMPACT ANALYSIS FORM**

DIRECTIONS: *Rate each barrier (A-Q) below, using the following key:*

5 = very high likelihood or impact, 1 = very low likelihood or impact.

Draw a line from the center, "0" line, to the appropriate number either to the left (Likelihood) or right (Impact) of the "0" line.

LIKELIHOOD **IMPACT**

5	4	3	2	1	0		0	1	2	3	4	5
						A						
						B						
						C						
						D						
						E						
						F						
						G						
						H						
						I						
						J						
						K						
						L						
						M						
						N						
						O						
						P						
						Q						

ACTIVITY #4

COMMITMENT TO ACTION

LENGTH OF ACTIVITY

15 *minutes*

Purpose: To assist participants in the identification of future goals related to the development of integrated options for young children with disabilities.

Description:

1. Give each participant a *Personal Commitment to Action* form. Ask participants to identify one thing tht they are going to do to help increase the integrated options for young children with disabilities. The activity should be written on the top half of the form. Participants should also identify a timeframe within which to complete the activity.

2. When finished with #1, ask participants to identify one person in the group who could be a resource in completing the identified activity. The resource person will contact the person completing the form on a mutually agreed upon date in order to provide support and encouragement. The identified resource person then signs the bottom of the form.

Additional Strategies:

Materials:

One *Personal Commitment to Action* form for each perticipant.

Audience:

Individual and small group

ACTIVITY 4

HANDOUT: PERSONAL COMMITMENT TO ACTION

I, ______________________________

(NAME)

RESOLVE THAT I WILL INCORPORATE THE FOLLOWING NEW IDEAS IN MY JOB BY ______________:

(DATE)

____

____

____

____

______________________________ ______________________________

SIGNATURE DATE

• •

ON ______________________________, I WILL CONTACT

(DATE)

______________________________ TO HEAR ABOUT, ENCOURAGE, AND SUPPORT

(NAME)

HIS/HER EFFORTS.

______________________________ ______________________________

SIGNATURE DATE

4 MODULE

PROBLEM SOLVING STRATEGIES & PREPARATION FOR INTEGRATION

OVERHEAD TRANSPARENCIES

TITLE PAGE

1. Module Four: Purpose 33
2. Module Four: Goals 35
3. Module Four: Participant and Trainer Expectations 37
4. Key Idea: Barrier and Solution Identification 39
5. Barrier and Solution Identification 41
6. Barrier and Solution Identification (cont.) 43

Module Four: Purpose

- Purpose: To provide information on problem solving skills and to provide solutions to identified barriers to integration

Module Four: Goals

- To provide information on techniques for identifying and clarifying problems and developing creative solutions to problems.
- To provide information on common solutions and strategies for preparing the entire early childhood setting for the integration of a young child with disabilities.

Module Four: Participant and Trainer Expectations

- The trainer will provide participants with the:
  - information enabling participants to identify strategies dthat will help facilitate the development of dtheir future roles and responsibilities
  - information enabling the participants to identify methods for preparing the child with disabilities and his/her family for integration into an early childhood setting
  - information enabling the participants to prepare other children and families in the child care setting for the integration of a young child with disabilities.
  - information enabling the participants to locate community resources for assistance when integrating a young child with disabilities.
  - information enabling the participants to develop problem solving skills related to the integration of young children with disabilities.

4 Key Idea: Barrier and Solution Identification

- There are often many barriers to the integration of young children with disabilities into regular early childhood settings. Some of the barriers may be easily solved, while others may take a more long-term, coordinated effort.

5

Barrier and Solution Identification

- Clarifying Barriers
- Generating Solutions
  - Preparations of the child with disabilities
  - Preparations of other young children in the environment
  - Preparations of other adults in the environment
  - Solutions to personal barriers
  - Solutions to programmatic barriers

6 Barrier and Solution Identification (cont.)

- Generating Solutions (cont.)
  - Solutions to community barriers
    - Certification/regulation barriers
    - Liability issues
    - Transportation issues
    - Funding issues